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RURAL HEALTH CARE DELIVERY IN ARKANSAS: IMPACT ON THE ELDERLY

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

SECOND SESSION

PINE BLUFF, ARKANSAS

AUGUST 30, 1988

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RURAL HEALTH CARE DELIVERY IN ARKANSAS: IMPACT ON THE ELDERLY

TUESDAY, AUGUST 30, 1988

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Pine Bluff, AR.

The committee met, pursuant to notice, at 1:30 p.m., at the Pine Bluff Convention Center, Pine Bluff, AR; Hon. David Pryor presiding.

Present: Senator David Pryor.

Also present: Portia Porter Mittelman, legislative aide; Ann Pride, press secretary; Tom Becherer, legislative correspondent; and Frank Thomas, administrative aide.

OPENING STATEMENT OF SENATOR DAVID PRYOR, PRESIDING

Senator PRYOR. Good afternoon, ladies and gentlemen. I'm very pleased to welcome each of you to this official hearing of the U.S. Senate Special Committee on Aging. Our subject today is the continuing struggle to ensure quality health care services in rural areas, particularly for our elderly population.

The Senate Aging Committee held two hearings on rural health care concerning these problems earlier in Washington, DC. These sessions focused on the special problems facing rural hospitals, as well as the critical need for increased health care personnel in rural areas.

Last winter, I spent 2 hours with the staff and the board of the Conway County Hospital discussing some of the problems as to Medicare reimbursement and other issues. Last spring, I had the privilege of attending a regular monthly meeting in Mena of the Wilhelmina Medical Center and Hospital monthly board meeting to talk about the everyday problems that a rural hospital faces and the crisis that we find in rural health care in our State and across our country.

Rural health care is of particular importance to Arkansas—58 of our 75 counties are designated as rural areas—yet only 31 percent of the physicians in the State, along with 38 percent of the registered nurses in our State, practice in rural localities. Fifty-one percent of the State's population reside in rural areas.

Access to quality health care is essential for our elderly residents; 14.2 percent of all Arkansans are 65 and over, compared with 11.9 percent nationwide. Arkansas is second only to the State of Florida in its per capita elderly population, with 12.3 percent of our senior citizens residing in rural areas.

Our subject this afternoon is particularly timely, in light of the very recent closing last week of Lee Memorial Hospital in Marianna. Another rural facility, Woodruff County Hospital in McCrory, near Augusta, is expected to close its doors tomorrow. Unfortunately, the hospital failures in our State reflect a national trend. Between 1980 and 1985, alone, an average of 36 community hospitals closed annually; that figure jumped to 71 in 1986. The failure rate of rural hospitals is on the rise; there's no question about that. In 1986, 52 percent of all hospital closings were in rural health care facilities. Arkansas has had seven hospitals close their doors since 1983. Which ones will be next?

The challenges of rural hospitals reflect distinct circumstances. These facilities often have tremendous difficulties, including shortage of personnel, rising costs, an inequity in the Medicare prospective payment system, and increased competition with their urban counterparts.

The Senate Aging Committee has been examining the overall rural health issue for several months. Later this fall, our committee in Washington will expect to release two reports—one on rural hospitals, the other on health care professionals in rural areas—each of which addresses in depth the unique difficulties of rural health care. Senator John Melcher, my colleague from Montana who is chairman of the Senate Aging Committee, will be using these two documents as the basis for developing legislation next year to address these problems that are so very severe. I look forward to joining with Senator Melcher and others in this effort.

We will explore the issue of rural hospital closings, health manpower shortages, and a host of other rural health care concerns with our panel of distinguished witnesses this afternoon here in Pine Bluff, AR.

Also, let me state, if I might, before we begin to hear testimony, let me take a moment to thank a number of people who have contributed to this afternoon's forum. First of all, our sincere thanks to the staff of the convention center for assisting us with the room provided for today's hearing. Several people with the Arkansas Department of Health were extremely helpful in preparing material for today's session, finding the facts and the statistics that will be so vitally crucial to the development of future legislation. Special thanks to Yvette Lamb and Beverly Brown in the office of primary care and Holly Roos in the office of aging. Dixie Clark, the director of Central Arkansas Area Agency on Aging and Madge Helm of the Arkansas Hospital Association have also provided a great deal of assistance and support as my office has prepared for this afternoon's hearing.

I would like to at this time extend my appreciation to each of those persons who have submitted written testimony for our official hearing record today, including Mr. Gary Hughes, the president of the Arkansas Home Health Association, and Mr. Frank Butts who is affiliated with Frost & Co. in Little Rock. Mr. Butts is currently working on a study for the Arkansas Hospital Association to assess the impact of the Medicare and Medicaid reimbursement systems. If we have ample time toward the conclusion of these proceedings, I hope to have the opportunity to call on Mr. Hughes and Mr. Butts for their brief comments, as well as the possibility of calling on others in the audience today who may wish to contribute.

We have also provided small cards; those cards are in the rear of the room. If you have not received one, if you would just hold up your hand, someone from my staff will be very willing to bring you one. We would invite your comments as to your particular—I see some hands going up. Please feel free to express anything you so desire on these cards. We would appreciate your name and address so that we might respond back to you. And if you wish whatever you recommend or state to be kept confidential, we would appreciate you writing that you would prefer this message to be kept confidential, and it will not be made a part of the record.

In retrospect, let me just say, too, that looking back, I wished a month ago we had thought of doing a full day's hearing rather than just an afternoon hearing because of the many, many of you who have called our office in Little Rock and in Washington expressing your desire to make a contribution and to say something at this particular hearing.

We have 10 witnesses today, and that's going to take a long time to go through all of the witnesses. All of these witnesses are extremely important; the contributions that they're going to make to the final hearing record we will appreciate very, very much.

Now, if we could get the cards out, we will, in the meantime, call our very first witness, Dr. Joycelyn Elders who is director of the Arkansas Department of Health from Little Rock. Also, I will also call at this same time the second panel. We will call Dr. Roger Busfield, president of the Arkansas Hospital Association; Mr. Jerry Campbell, the administrator of the Johnson County Hospital in Clarksville; and Mr. Franklin Montgomery of the Lee Memorial Hospital that just closed in Marianna only last week. We will ask Dr. Elders to bring us her testimony at this time, and we will now turn the podium over to Dr. Elders of the Arkansas Department of Health from Little Rock.

Dr. Elders, we appreciate you coming this afternoon; we look forward to your contribution.

STATEMENT OF DR. JOYCELYN ELDERS, DIRECTOR, ARKANSAS STATE HEALTH DEPARTMENT, LITTLE ROCK, AR

Dr. ELDERS. Thank you, Senator Pryor.

Senator Pryor and distinguished members of the committee, I am Dr. Joycelyn Elders, director of the department of health and chairman of the Governor's Task Force on Rural Hospitals. I am here today representing public health concerns and rural health concerns of the citizens of Arkansas.

I would like to give an overview of some of the problems faced in delivering health care in rural areas and describe one measure which may be important for ensuring access for health care, particularly for the elderly.

Arkansas is a predominately rural State, with a population of 2.4 million; 60.7 percent of whom live in towns of 2,500 or less, compared to the national average of 23.4 percent. Arkansas is also an "elderly" State; 14.2 percent of Arkansans are aged 65 or older, placing us fifth in the country by that measure. Thus, we have a higher incidence of death from cancer, heart disease, and strokes than the national average.

Changes in rural America and the health care marketplace are posing problems for rural health care in four major areas. These are: health care manpower, health care financing, health care service delivery or utilization, and hospital closure.

Over 700 rural hospitals have closed in the past 15 years. More than one-third of these were in the delta region, and seven hospitals closed in Arkansas during the past 2 years. Arkansas has 92 hospitals, 58 of which are less than 100 beds. Most of these small hospitals have an average daily census of less than 44 percent capacity. Admissions to rural hospitals have declined 22 percent between 1979 and 1985, while admissions to urban hospitals increased slightly.

In 1985, fewer than 15 percent of all physicians practiced in rural areas, where 23.4 percent of the Nation's population lives. In Arkansas, 69 percent of our physicians are in urban areas where 39 percent of our population lives. Conversely, 60.7 percent of our population is in rural areas where only 31 percent of our physicians practice. From 1985 to 1986, the number of office-based physicians in rural areas dropped by 9 percent. And, despite the growth in medical specialities during the decade, less than 12 percent of those specialists practice in rural areas. In Arkansas, 72 of our 75 counties are designated as fully or partially medically underserved.

Why are rural hospitals facing financial distress? In the last decade, the economy of many rural areas has weakened. The unemployed and underemployed are less likely to have health insurance. As a result, rural hospitals provide a large amount of uncompensated care. Weakened rural economies also exacerbate the population decline and make it more difficult for hospitals to finance themselves with local donations and tax revenues. Economic problems and declining populations also make it difficult for rural communities to attract and support physicians and other health care professionals. As a result, access to high quality health care is becoming increasingly difficult for our rural residents.

During the last decade, changes in the health care marketplace have also negatively impacted on rural health care. Medicare's 1984 implementation of prospective payment systems resulted in Medicare paying rural hospitals 36 percent less overall than urban hospitals for the same services. New technology has increased outpatient and ambulatory services, and rural hospitals have been disproportionately affected by lower patient volumes. The concentration of high technology in urban medical centers lures physicians and patients away from rural communities. The outflow of patients and dollars further threatens the viability of rural hospitals and medical practice.

When a rural hospital closes, the impact on the local economy can be great. In many rural areas, the hospital is one of the largest employers. Further, the lack of adequate health care systems makes it more difficult for the rural community to attract new business.

What can we do in Arkansas? We can begin to implement strategies for change that ensure high quality basic health care for our rural citizens. I believe community-based primary health care is every citizen's right. Primary care includes maternity care, child health supervision, emergency medical services, transportation to services, and long-term care. To secure this right for our rural citizens we must:

First, restructure our service delivery system in ways that optimize the resources and benefits of hospitals, ambulatory care centers, and in-home health services;

Second, creatively and aggressively recruit health professionals for rural communities;

Third, address inequities in hospital payment systems and health care coverage for the medically indigent; and

Fourth, evaluate our rural hospitals and be willing to subsidize those that are essential, help those to diversify that are in need of diversification, consolidate or convert those that serve an essential need but are unable to do so because of lack of central resources, and close those that are in reasonable proximity to other resources and lack the professional manpower, financial stability, and community commitment to service utilization.

We then need to subsidize those essential services that are the rights of all of our citizens, such as emergency room service or transportation to receive those services, obstetrical and perinatal care, primary care for children, care for chronic disease, and in-home services and long-term care facilities.

I would like to spend the remainder of my time discussing how in-home health services can be an important measure for insuring access to health care, particularly for our elderly. In the face of a rapidly aging population which need more and more health care—both acute and long-term care—we must deal with the fact that there are many instances when people could be receiving their care at home, where families want to help and where care can be less costly, yet our reimbursement systems don't allow the possibility for care at home.

Visualize, if you would, how it might be if Medicaid policies didn't force some people to enter nursing homes when they really don't need to be there. Visualize, if you would, how it might be if Medicare policies allowed some illnesses to be managed at home through nursing care for limited periods where their families and loved ones could provide the care at much less cost.

Two measures can make this a reality: the inclusion of extended-hour nursing as a short-term Medicare benefit and the equalization of Medicaid eligibility for nursing home and in-home long-term care services. Two factors would be a prime consideration in implementing such benefits; these are cost and quality. Medicare hospice programs have shown us that home nursing services, provided several hours a day coupled with volunteer and family efforts, can be very effective at low cost. Assuring quality, however, is more difficult and would be critical. Mechanisms to accomplish this would need to be carefully designed with the patient's safety in mind.

If a person needs supportive care rather than nursing care, then home is perhaps the best place. Supportive care is available and includes services such as personal care, homemaking, and transportation. The problem with patient access to these services lies not in the availability of services but with Medicaid eligibility policies.

In summary, our rural health problems can be categorized into three broad areas: professional manpower, health care financing, and service delivery systems. The basic needs and rights of all of our citizens include long-term care facilities for chronic disease, in-home services, emergency services, stabilization and transportation, and primary care for obstetrics and children.

Senator Pryor, we know that you are concerned about the health issues facing the elderly of rural America and Arkansas, or you wouldn't be here today. As Congress considers appropriate measures, we urge you to consider all the testimony you've heard as you've traveled around the country and that you will hear today. We urge you to reevaluate prospective payment system practices that negatively impact rural areas and we urge you to consider changes in Medicaid and Medicare policies which affect access to in-home services. I trust your committee to deal with these issues creatively, compassionately, and correctively, such that we may be able to provide the basic health care needs of all Americans living in rural areas.

Thank you. [Applause.]

[The prepared statement of Dr. Elders follows:]

TESTIMONY BEFORE THE
U. S. SENATE SPECIAL COMMITTEE ON AGING

THE RURAL HEALTH CARE CHALLENGE

August 30, 1988

Pine Bluff, Arkansas

by:

Dr. Joycelyn Elders
Director
Arkansas Department of Health

Statement for Pine Bluff - August 30
Rural Health and Elderly
Senator Pryor's Committee

Mr. Chairman and distinguished members of the Subcommittee, I am Dr. Joycelyn Elders, Director of the Arkansas Department of Health. I am here today representing the public health concerns of the state.

I would like to give a brief overview of the problems faced in delivering health care in rural areas. I would also like to describe how in-home health services can be an important measure for ensuring access to health care, particularly for the elderly.

Arkansas is a predominately rural state, with a population of 2.4 million. 60.7% of Arkansans live in towns of 2,500 or less, compared to the national average of 23.4%. Arkansas is also an "elderly" state. 14.5% of Arkansans are age 65 or older, placing us fifth in the country by that measure. Rural populations tend to be older. According to 1985 data, 12.3% of rural poplations are age 65 or older, compared with 10.4% in metropolitan areas. Our problems in delivering health care in rural areas have a negative impact on the health of many of our elderly.

The problems of delivering health care in rural America have reached the crisis stage. Over 700 rural hospitals have closed in the past 15 years. Admissions to rural hospitals declined 22% between 1979 and 1985, while admissions to urban hospitals increased slightly. In 1985, fewer than 15% of all physicians practiced in rural areas, where 23.4% of the nation's population lives. From 1985 to 1986, the number of office-based physicians in rural areas dropped by 9%. And, despite the growth in medical specialities during the decade, less than 12% of specialists practice in rural areas. In Arkansas, 72 of our 75 counties are designated as fully or partially medically underserved.

Charges in rural America and the health care marketplace are posing problems for rural health care in three broad areas: health care financing, manpower, and service utilization.

First, let me describe how rural changes are adversely affecting health care delivery. In the last decade, the economy of many rural areas has weakened. This places a financial strain on rural hospitals, The unemployed and underemployed are less likely to have health insurance. As a result, rural hospitals provide a large amount of uncompensated care. Weakened rural economies also exacerbate the population decline and make it more difficult to finance hospitals from local donations and tax revenues. Economic problems and declining populations also make it difficult for rural communities to attract and support physicians and other health care professionals. As a result, access to high quality health care is becoming increasingly difficult for rural residents.

During the last decade, changes in the health care marketplace have also negatively impacted on rural health care. Medicare's 1984 implementation of prospective payment systems resulted in Medicare paying rural hospitals 36% less overall than urban hospitals for providing the same services. New technology has increased outpatient and ambulatory services and rural hospitals have been disproportionately affected by lower inpatient volumes. Forty-four percent of rural hospital beds are empty on an average day. The concentration of high technology in urban medical centers lures physicians and patients away from rural communities. The outflow of patients and dollars further threatens the viability of rural hospitals and medical practices.

When a rural hospital closes, the impact of the local economy can be great. In many rural communities, the hospital is one of the largest employers. Furthermore, the lack of an adequate health care system makes it more difficult for a rural community to attract new business.

We must implement strategies for change that ensure high quality basic health care for our rural citizens. I believe community-based primary health care is every citizen's right--that includes maternity care, child health supervision, emergency care, and long-term care for chronic illness. To secure this right for our rural citizens, we must:

1. restructure our service delivery systems in ways that optimize the resources and benefits of hospitals, ambulatory care centers, and in-home health services.

2. creatively and aggressively recruit physicians.

3. address inequities in payment systems and health care coverage for the medically indigent.

In the face of a spiraling aging population which needs more and more health care, both acute and long term, we must deal with the fact that there are many instances when people could be receiving their care at home, where families want to help, and where the care can even be less costly, yet our reimbursement systems don't allow the possibility for care at home.

Visualize, if you would, how it might be if Medicaid policies didn't force some people to enter nursing homes when they really don't need to be there.

Visualize, if you would, how it might be if Medicare policies allowed some illnesses to be managed at home through nursing care for limited periods, with their family and loved ones, at less cost.

Two measures could make this a reality:

1. The inclusion of extended-hour nursing as a short-term Medicare benefit

2. The equalization of Medicaid eligibility for nursing home and in-home long-term care services.

First, the reason for the needed change in Medicare: some patients who are not critically ill, but require symptom management or other short-term measures, might safely receive their nursing care at home.

All-day home nursing services would enable some of these patients to recover at home.

Two factors would be of prime consideration in implementing such a benefit under Medicare: cost and quality.

Provided that only necessary care is reimbursed, a cost savings could result. Medicare Hospice services have shown us that home nursing services provided for several hours a day, when coupled with volunteer and family efforts, can be effective at a very low cost: 12 hours of daily nursing care could be provided at a daily cost of approximately $180--compared with several hundred dollars per day for hospital care.

Assuring quality care would be critical. Mechanisms to accomplish this would need to be carefully designed with the patient's safety in mind.

The need for equalizing Medicaid eligibility for long-term in-home services and nursing home care stems from information that is probably familiar to you. As a member of the U.S. Senate Aging Committee, you have no doubt heard considerable testimony that many nursing home patients don't really need nursing care, but need supportive care. And you no doubt have heard staggering projections about the skyrocketing numbers of persons over 85, and what this will mean about the need for long term care services, and the potential long-term care funding crisis we are facing as a nation.

If a person needs supportive care, rather than nursing care, then home is possibly the best place for that person. Supportive care is available and includes services such as personal care, homemaking, and transportation. The problem with patient access to these services lies not in the availability of services, but with Medicaid eligibility policies.

Currently, Medicaid policies will pay for nursing home care if a person's income is up to approximately $1,000 monthly. For supportive services and home health care, a person's income must be approximately under about $350 monthly. It is easy to see why so many people have no choice but to go to a nursing home, when they really don't want to, and when all they really need is supportive services.

I know that the Medicaid program must not be exposed to drastic increases in cost. Therefore, the challenge is to offer supportive services to increased numbers of persons in their homes without increasing Medicaid's overall cost. Utilization controls and coordination of services will be critical to the control of cost. But the cost difference per patient is staggering: Arkansas Medicaid information indicates that annual Medicaid outlays per nursing home patient are almost three times that of personal care patients; $9,500 per year for nursing home, and only $3,540 for personal care!

Thus, meeting the challenge successfully would mean that many more people could stay at home longer, until they need nursing care. During that time, they can enjoy their home, their family and their own independence and dignity. A tremendous improvement, if it can be accomplished without increased cost to Medicaid.

Senator Pryor, we know that you are concerned about the health issues facing the elderly of rural America and Arkansas, or you wouldn't be here today. As Congress considers appropriate measures, I hope that you will push for these two fundamental changes to our reimbursement systems. They could affect so many lives.

Thank you.

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Senator **Pryor**. Dr. Elders, thank you. I have one or two questions, and any of the questions that I do pose to any witness this afternoon, they are free to either answer the question now or will have five days to submit their answers in writing, and those will be made an official part of the record which will go to Washington, DC.

You know, during a Presidential election year, every 4 years, we in our American political system sort of have a way of reexamining or asking the American public about the role and the relationship between the government and the people—how much government and how little government, how much intrusion and how little intrusion. I think one of the main questions being asked in 1988, not only in the other 49 States as we go about electing a new President, but it's also a question, I'm sure, that people are asking you and your department, the Arkansas Department of Health, and that question is this: How much should the government do, let's say, on the State level or the Federal level or the local level, the county level; and how much should be done by individuals on the local level? And it's my understanding that you are now conducting some questions and interviews in a series of hearings throughout the State to ascertain some answers to this question. I wonder if you might have any initiatives you would like to share that you've picked up or any thoughts that you might be willing to give us from your early studies thus far?

Dr. **Elders**. Senator, we are, as you said, conducting some long-range planning town meetings around the State to find out what it is that the people of Arkansas would like for us, as a health department, to do and be involved in. We have heard from many and most have definite ideas. I think one of the things that's become very clear to us is that citizens would like to become more involved at a community level with assistance from those of us working at the State level. They certainly are very aware that they can't provide all of the services themselves, but they feel that some of their individual community needs are different from the perceived needs at the State level.

Senator **Pryor**. We see today in this room, Dr. Elders, I know an awful lot of the individuals sitting here. I've been trying to look out; I can't see too well because of the lights. But I see out here several members of our State legislature. They're being asked these same questions that you are and that I'm asked on a daily basis. I see several doctors, physicians, and nurses, and people who are staffing some of our hospitals throughout the entirety of our State. I also see many of these board members of these hospitals who serve without pay as a community effort and as a dedication to that community and to better health care. And I think that everyone today is in a quandary as to what step we take next.

I know in my visit to Mena, and then in my visitation with the people from Morrilton in the last several months, I was absolutely astonished at the daily problems. For example, I remember sitting there with the people in Mena, and I say this in all due respect, some of the Little Rock hospitals were offering their RN's there at the Wilhelmina Medical Center a great deal more money to leave Mena, AR, and move to Little Rock. Now, that's competition. But it's competition that is really putting a very great deal of stress and strain especially in our rural areas. It's ultimately going to get where we're seeing this now. Where in some cities like Boston, Chicago, New York, and San Francisco, they're now trying to lure our remaining RN's from the State to their cities and to their States. So, we, I think, are going to first have to look at this area of how not only do we educate but entice and encourage more to become RN's and LPN's and staff members in our hospitals.

Now, second, you mentioned the need, in your statement, Dr. Elders, of long-term care services. This is going to be one of the critical issues of 1989 and 1990 in the Congress of the United States. Do you have any provisions, Dr. Elders, that you would like to see included in any long-term care legislation Congress might develop?

Dr. ELDERS. Senator, from what I've gathered from talking with people that need long-term care, a need that is predominately one of the elderly, I think some changes or some waivers in our Medicare and Medicaid policies would allow more of our elderly to stay at home. We pay a very different rate for our elderly in nursing homes than we pay when they remain in their own homes. And we, also, often do not pay for services that could be provided at home but will pay for those services if they are provided in a nursing home or hospital. So I think that as we respond to a rapidly aging population we certainly feel we need our nursing homes; we need the nursing home reimbursements that we have. But rather than just constantly expanding the number of nursing home beds, we need to provide better compensation and more compensation for our patients in their homes. We would also recommend that you look at the prospective payment systems based on DNG's that compensate rural hospitals at a much lower rate than they do even urban hospitals in our own State.

Senator PRYOR. I think about 35 percent or 36——

Dr. ELDERS. 36 percent.

Senator PRYOR [continuing]. Percent less.

Dr. ELDERS. Less.

Senator PRYOR. All right. Now, do we have any statistics, you may have alluded to it in your next to the last page of your testimony, about how much it takes to look after, sufficiently, an individual in their own private home, using home care services, versus that figure it takes to keep them in a nursing home?

Dr. ELDERS. These figures were recently looked at, Senator, by the Arkansas Department of Human Services, and their data would suggest that it costs approximately $3,500 a year to keep an elderly person in their home with in-home services, as opposed to $9,500 a year in a nursing home.

Senator PRYOR. Now, that's of State money, or——

Dr. ELDERS. Well, the State money, I think, is approximately $2,000 for the nursing home; $2,200, I think, may be more exact; and it's about $700 of State money for in-home services.

Senator PRYOR. I see.

Dr. ELDERS. So the match is four to one.

Senator PRYOR. Do we have any statistics for Arkansas as to how many people today are residing in nursing homes that should not be there?

Dr. **Elders**. Well, of course, Senator, it's very hard, you know, to answer that question. I think we hear numbers tossed around, but I'm not sure that we have an accurate number as to the number of people that are residing in nursing homes that should not be there. But I think we all would agree that that are some people that are residing in nursing homes that could be cared for in their local community.

Senator **Pryor**. There's a feeling that I have—I've talked to several people who are in the medical delivery system, and they say that out in the State some of these hospitals that are closing—for example, like Lee County, and tomorrow in McCrory, and Lafayette County, and other hospitals. In fact, for the record, we ought to, just for the record, state this. Since 1983, the Calhoun County Hospital, Hampton; Lee Memorial Hospital, Marianna; Woodruff County Hospital, McCrory, that's tomorrow; Lafayette County Hospital, Lewisville; the Gurdon Hospital; England Hospital; Brinkley Hospital—just since 1983. That is a very, very rapid decline of health care that we see that presents this crisis situation. Some people are saying that these should be turned into nursing homes. I don't know whether that's a good suggestion or a bad one; I just don't know. Do you have any comments on this?

Dr. **Elders**. Well——

Senator **Pryor**. Or do you want to wade off into that issue?

Dr. **Elders**. Well, I probably shouldn't wade off into that issue, Senator, but I think that our task force on rural hospitals' thinking is that if emergency care is not within 30 minutes of another facility, if a hospital does not have the medical manpower to provide primary care for its community patients, we must find ways to provide those essential medical services. Perhaps some small rural hospital beds could be used as long-term care beds because as you know, we definitely need long-term care services and in-home health services accessible in all areas.

Senator **Pryor**. Dr. Elders, I want to thank you. I'm going to ask, if you would, not to go back out in the audience for a moment, because our next panel may have comments that you may want to respond to. We're going to try to informalize this a little bit, and I'm going to ask our second panel to begin.

We first have Dr. Roger Busfield, Ph.D., he's the president and CEO of the Arkansas Hospital Association. Roger is certainly no stranger.

Then we have Mr. Jerry Campbell. Now, I believe that Jerry is representing 13 of the hospitals in the Arkansas River Valley region, and he is going to talk about some of the rural hospital problems that they have in the Arkansas Valley area.

And then we have Mr. Franklin Montgomery, administrator, or I should say former administrator, late administrator, of the Lee County Memorial Hospital in Marianna; and he's going to tell us what happened in Marianna, what's happened in Lee County to that little hospital that existed for so long and that served so many.

Dr. Busfield, we'll call on you first.

Now, by the way, if you fellows get too long winded, I may have to sound the gavel, and we'll put all of your statements in the record. We want to hear everything you have to say, but in the interest of time, we hope that you will summarize. But if you have a full statement, you go ahead, and we'll see how long it takes.

Dr. Busfield.

DR. ROGER BUSFIELD, PRESIDENT AND CEO, ARKANSAS HOSPITAL ASSOCIATION, LITTLE ROCK, AR

Dr. **Busfield**. Thank you, Senator Pryor, and good afternoon.

You pretty well summarized the hospitals that have closed and the fact that one will close tomorrow. Another closed and reopened its doors in northeast Arkansas, but the patient load is too small to allow it to continue operating for very long. We have at least 12 hospitals and perhaps 15 that could possibly close within the next 18 months to 2 years, unless there is a drastic reversal in the number of patients being admitted and treated in these hospitals.

Some of these endangered hospitals, Senator, could perhaps be converted to a combination of long-term care and the new medical assistance facility, or MAF, an experiment in Montana that has the support of the Health Care Financing Administration. These MAF's provide inpatient care to ill or injured patients prior to their transportation to a hospital or provide inpatient medical care to persons needing that care for a period no longer than 96 hours or 4 days. The Montana MAF's are located in counties with fewer than six residents per square mile or located more than 35 miles from the nearest hospital. Now, we have reported this MAF experiment to our Arkansas hospitals, and we're monitoring it very closely to see if it has any applications to Arkansas.

Now, I want you to understand that some of our rural hospitals are doing quite well, while others are struggling because of a combination of factors. Some of Arkansas rural areas are without any physicians at all, while other of our rural areas have plenty of physicians. And there are still other areas that have physicians, but these physicians rarely admit patients to the local area hospital.

Now, let me give you an example of two hospitals approximately the same size. One is located in southwest Arkansas, the other in the southeast part of the State. The hospital in southwest Arkansas is in an area where there are at least five family practitioners, but these physicians treat very few of their patients in the hospital. If the physicians admit patients, they are usually very ill. If the patients need surgery or need to have bones set or have to be delivered of a child, then these physicians send their patients "down" the road or "up" the road to another hospital. In other words, these physicians seldom, if ever, "cut, deliver, or set." Why should they? With malpractice rates as high as they are, especially if you elect to deliver babies, it's easy and less expensive to make a living by seeing patients in their offices and shipping them elsewhere for surgery or delivery.

Now, the hospital in southeast Arkansas is located in a community with an interesting physician mix. There are older physicians there who are general practitioners whose shingles still say "physician and surgeon." Now, when the newer, younger physicians—the family practitioners—move to town, they know that if they are to compete they will have to "cut, deliver, and set." And there are no occupancy problems in this community in southeast Arkansas.

When malpractice rates can cripple health care and lead to the closure of a hospital, which may happen in our southwest Arkansas area, then something is drastically wrong with the system.

There is a general fear among physicians that their medical decisions are going to be challenged. Physicians no longer control the medical needs of their patients. Approval must be sought in advance of every elective Medicaid admission. Medicaid, Medicare, and in some cases, Blue Cross and Blue Shield, are reviewed retrospectively by a federally funded organization or by Blue Cross and Blue Shield to determine if the admission was necessary or whether it was something that could, but not necessarily should, be treated on an outpatient basis or in a physician's office. The physician's judgment is constantly challenged and second guessed. Put yourselves in their position. Wouldn't you become overly cautious in admitting patients to a hospital? Of course you would.

Has Congress checked to see if the cost of policing the medical and hospital community really results in true savings? Just how much does it cost the American taxpayer to fund the review process, the investigation of alleged fraud and abuse, and the cost of the various regulating agencies within the Department of Health and Human Services or funded by that department?

The present system of reimbursing hospitals, as indicated by Dr. Elders, penalizes certain hospitals and rewards others. But take two smaller hospitals—two rural hospitals but 22 miles apart in central Arkansas. One is in the Little Rock Metropolitan Statistical Area, or MSA; the other is in an adjacent county 22 miles away regarded as rural. Yet there is as much as 40 percent and more difference between the reimbursement of identical procedures at both hospitals. The rural hospital suffers; the smaller hospital within the MSA does a little better but still doesn't get what it actually costs to render the care.

The irony of this example is that frequently the same surgical team will perform the same procedures at both hospitals. The complete team, including the anesthesiologist, will be at both hospitals, yet the 40 percent or more differential between the two hospitals exists. It just doesn't make much sense.

Finally, I ask that you carefully review the written testimony of Frank Butts of the Frost Co. The Arkansas Hospital Association, as you said, commissioned this firm to assess the impact upon our hospitals of the current reimbursement systems for Medicare and Medicaid. Copies of Mr. Butts' testimony are available here today for your perusal.

And, Senator Pryor, upon behalf of the Arkansas Hospital Association and the hospitals of Arkansas, I thank you for this opportunity to offer this very brief statement on the plight of our rural hospitals. [Applause.]

Senator PRYOR. Dr. Busfield, thank you very much. We may have some questions in a moment.

Mr. Jerry Campbell of Johnson County Regional Hospital, Clarksville, AR. Jerry.

STATEMENT OF JERRY CAMPBELL, ADMINISTRATOR OF THE JOHNSON COUNTY REGIONAL HOSPITAL, CLARKSVILLE, AR

Mr. CAMPBELL. Thank you.

Chances are that you or someone close to you is going to need medical care in the next few years. But even if you do not need so much as a bandaid or a flu shot, you may be paying for or helping to pay for the bills of people who do.

I am from a very proud small hospital in the Ozarks, and we're glad that we're able to live in a country where the people, the government, and the issues can come together like we are this afternoon, and we hope that this will be useful. And much more important than the meeting today is the plight of our hospitals, and we should celebrate our ability to address these problems and solve them.

The hospitals that I represent came together last week, and we agreed that to do the best we could today we would focus on a few areas that if we got outstanding results would take us forward the greatest distance. Senator Pryor, these issues that we have identified are:

First, inadequate reimbursement.

Second, poor definitions. We hear very much from Richard Kusserow, the inspector general, and from William Roper of HCFA, but we don't get the definitions we need of reasonable access for our patients, definition of the term "quality," definition of the term "fair return on investment," and definition of "right to survive."

Third, the area where we believe we can get the most outstanding results is manpower recruitment and retention.

Fourth, the primary care in rural health.

Fifth, and long-term care. You see here that hospitals are saying: "Yes, there are other services besides hospitals that need to fit our complete picture—primary care and long-term care."

Senator Pryor, our hospitals want few things, but these things we must insist upon to survive. As we address these issues today, let me first ask us some hard questions:

Does Congress intend for HCFA to drive rural hospitals out of business?

Does Congress intend that small hospitals be disproportionately impacted under Medicare's cost containment initiatives?

Is Congress aware that legislation that was designed to speed up Medicare payments 2 years ago was, in fact, implemented in such a way to have the net effect of significantly slowing down Medicare and Medicaid payments?

Now, Senator Pryor, you and Dr. Elders have already talked about the need for more doctors and nurses, which brings me to the next one: Is Congress aware that the wage index component actually has the impact of exaggerating the maldistribution of doctors and medical personnel? And for those of you who are not clear on that, in Arkansas we are only reimbursed 79 percent of the National average for health care index component. And we have to compete with Baltimore and Dallas and everywhere else to get the talent we need to provide you with the care you deserve.

And, finally, is Congress sensitive to how totally insecure our voting population feels about the continued access and quality of health care delivery system?

In this era of Gramm-Rudman-Hollings, it is important that the money we spend for health care not be too little, not be too much, or tied to unuseful or inaccurate assessments. I believe that we are here today because we know that the system cannot remain unchallenged or unchanged. Thirty-seven million Americans have no health care coverage at all. Another million become impoverished every year as they try to pay for extended care which costs on the average of $22,000 a year. But remember, too, that over 60 million people in the United States live in rural America.

In the mid-1960's, President Kennedy and President Johnson promised that we would extend Social Security to include complete medical care for the aged in very precise wording. And at that time, a lot of people said "That's wonderful." They breathed a sigh of relief, and then they spent more money fixing up their farm and more money sending their kids to college. And as soon as they retired on a fixed income, the rules in Washington changed. And now we have tens, maybe hundreds, of thousands of people living on that unkept promise.

The population growth has leveled off. The percentage of people in retirement, relative to the number of people who are working, has increased a little ahead of the plan. Interest rates that are available on the savings of these people has declined. And, again, the rules from HCFA have changed. The deductible now is $510 a year just for the hospital component.

What does this mean? This means, well, let's talk about Arkansas specifically for a second. Dr. Elders has already pointed out that we're second only to Florida in the number of retired people per capita. Now, let's talk about a few other numbers. Did you know that there are fewer hospital beds per capita in Arkansas than 95 percent of the States. OK, and not only are there fewer beds, there are fewer dollars spent per bed. Now, take all of this together, and what does it mean? It means that when experts in Washington predict that 2,000 hospitals across the United States will go out of business, they're talking about Arkansas. And for you out-of-towners, I'll tell you that they're also talking about Mississippi, Louisiana, and Texas. The evidence is already in. Recently, 20 hospitals have closed in Texas and 7 in Arkansas.

About 700 of the 5,700 hospitals in the United States will close by 1995, according to a recent report by Arthur Anderson & Co. and the American College of Healthcare Executives. The most endangered species: small, rural, county-owned hospitals like mine.

Now, William Roper, the head of the U.S. Health Care Financing Administration, says that the Nation is "wringing out excess capacity out of the system." But Mr. Roper confuses some definitions. He says that if a hospital is going out of business, it's because they must be inefficient and not of good quality. I suggest to Mr. Roper that any hospital that routinely gets paid less than costs for their government patients, a component that's 66 percent of my activity, is going to go out of business regardless of the quality, regardless of the efficiency, and whether or not it has a very large service area, like mine does, and is needed in that area and meets the definition of complete community that future employers are looking for when they decide whether or not to bring their plants to the beautiful valleys of Arkansas.

I would like to suggest today that Washington's definition of efficiency should not be confused with the needs of the citizens of this State of Arkansas. Our citizens should not have to drive 30 to 100 miles to get the care that they were promised 25 years ago.

Hospitals do more in the towns of Arkansas than just provide health care. They provide community services, most of them without a return on investment; they provide educational opportunities; they help every community meet that definition of completeness that attracts industry and potential employers. Most of the hospitals that I represent today are league leaders in terms of the numbers of employees that they have, the average salary for that community, and the average total payroll for that community—strong, economic players in the small communities that we're talking about today.

I'll omit a few paragraphs after hearing the comment from Senator Pryor.

Nearly half of the Nation's hospitals lost money treating Medicare patients last year, and many of the financially battered smaller hospitals in rural areas are in danger of shutting down, Federal officials reported the first of this month.

Let's talk about how we measure PRO performance. Peer review organization performances are measured by the percentage of cases reviewed. Their performance and their rate of pay is higher for 100 percent review of hospitals. And folks, think about it. It is easier to 100 percent review smaller practices and smaller hospitals than it is larger practices and larger hospitals in the larger cities. Their marching orders: reduce admissions. Net effect: Rural hospitals have a higher percentage of reviews, even though this brings the least dollar effect.

Directive and instructions from Washington, directives and instructions from Baltimore, directives and instructions from the Medicare intermediary in Little Rock, directives and instructions from the PRO in Fort Smith, directives and instructions from HCFA in Dallas. The small and rural hospitals do not have a staff of 22 administrators to read, understand, and respond eloquently to these instructions and directives. Knowing this, the rural hospitals become the path of least resistance for PRO's and Medicare intermediaries. Again, ladies and gentlemen, the net effect is that rural hospitals have the greater percentage of the attention given even though this yields the least dollar effect and the least savings for the Federal Government.

Let's talk about the doctors. Retrospective denials have an impact on our doctors as well. When doctors find out 90 days, 6 months, or even years after a case that someone in a glass office thousand of miles away has decided that they've changed their mind about whether they should be paid for that case or not and the money is then withheld, they are driven to avoid Medicare rather than risk coming under 100 percent review. This disenchants the physicians we already have and it repulses new doctors in the area. The net result: quality goes down; access goes down. To some of you, this is no surprise, but our denial rate in Arkansas is higher than the denial rate in the surrounding States. And the office charge payable to our doctors is less in Arkansas than it is in surrounding States. And then we wonder why Arkansas can't attract physicians. Patients in Arkansas are being undertreated. And while HCFA does not intend to put hospitals out of business, again that is the net effect.

The annual Medicare deductible. That was originally based on cost per patient day with a fixed volume. OK, guys, remember that the instruction was to reduce admissions. And when you reduce admissions, you reduce volume. And that's why the average deductible now has gone up to $540 a year. I have a problem with that, personally, and so do my doctors. And that is that $540 is a lot of money—OK?—especially if you're on a fixed income. And what we're finding now is that people aren't coming in when they need to because they don't want to or can't pay that deductible. They wait longer; they get sicker. And we don't get reimbursed because the DRG is the same, but the output and the outcomes are far more sinister.

Senator Pryor, doctors avoiding the possibility of a denial delay the admission of that patient. The patient becomes sicker and, if still alive at the time he gets to the hospital, now needs far more intense treatment than he would have needed originally.

In nursing homes, the decision to pursue hospital care for nursing home residents is also delayed. Do we know to what degree this has impacted the increase in the number of deaths in rural Arkansas?

Our Medicare intermediary's evaluations are based on the dollar saved as a percentage of costs of recovery. This creates an auditing problem, and it raises some serious questions as to what are our intermediary's costs per claims processed. Right now, the motivation is to keep cases on 6-, 7-, and 8-year-old appeals. Where are the resources and where is the manpower for small hospitals to handle these kinds of retrospective IRS-type reviews?

In Arkansas, a lot of people in our valleys are not on Medicaid, even though they qualify. Sixty percent of the denials for Medicaid benefits are for technical and not qualification reasons. And the State of Arkansas could attract far more Federal dollars into the Medicaid Program if it complied with the minimum requirements.

Another issue is manpower. The recruitment and retention of technical personnel—and I'm not talking just about nurses and family practitioners—into the rural areas is hard to find when we're being allowed only 79 percent of the national average for the Federal wage index factor across the board in Arkansas. Remember that the rural hospital has to compete with the large cities for technical personnel. They are trained in the cities and they are paid in the cities and will not leave those cities to go to a rural hospital for a cut in pay.

Now a second about capital costs. Capital costs are often actually higher, not lower, in smaller hospitals. This has nothing to do with quality or efficiency. It has to do with the fact that when we buy a scanner or an analyzer it may work only four hours a day. If it's in a major urban city, it will work 24 hours a day. But there's another reality in the total picture of health care delivery today, Senator Pryor, and that is this one: the patients who will make the difference are the paying patients, and patients that know that they can pay will drive right past mediocre on their way to quality. And this changes the recipe for surviving hospitals. We have to be quality; we have to have the scanner; we have to have the analyzer to be a hospital.

Today I invoke you to take heed, to think wisely, and to commit to the success of health givers throughout the fields and valleys of Arkansas and these United States. Those few areas in the total picture where we believe that together we have the opportunity for the most outstanding results are as follows:

First, study for objective understanding the work methods, evaluation methods, and payments to the peer review organizations and the Medicare-Medicaid intermediaries to guarantee reinforcement of congressional intent and access to quality care to which our government has been committed for a quarter of a century.

Second, review those same costs and methods of intermediary contractors to assure appropriateness and scale equity. Study the possibility of a separate system for hospitals of 100 or less beds, if they are carrying the sole provider demands and responsibilities of a significant geographical service area.

Third, please give your attention and understanding to the Frost report for the Arkansas Hospital Association on the effect of Medicare and Medicaid on Arkansas hospitals.

Fourth, promote programs, payments, and evaluations that yield cost effective ways to deliver mental health, chemical dependency, and smoking cessation care.

Fifth, delete variances from the wage-index component that have the effect of keeping talent and doctors out of Arkansas and promote programs to attract primary care physicians and technical personnel to this State.

Sixth, review the original basis and intent of the Medicare deductible. Which costs more—participating in reducing that deductible or treating the delayed geriatric patient?

Seventh, send a clear message to HCFA, to Congress, and to the White House that care givers cannot be abused indefinitely; that some of the harm we do today is permanent.

In my best vision for the future, the United States will continue to prosper, and the population will continue to age. There will be more people living; there will be more people driving cars; and more people taking risks in sports. The demand for health care delivery services will increase. But because of the questions that you are asking today, we will stop spending more money on the projects we can no longer afford and get back to the basic needs of those around us. We will have the courage to review the commitments that we have made and live by them. And we will resolve the inequities and renew the partnerships between health care payers and health care providers.

Thank you. [Applause.]

[The prepared statement of Mr. Campbell follows:]

Testimony of Jerry Campbell before the
Senate Special Committee on Aging
Pine Bluff, Arkansas
30 August 1988

TO MAINTAIN A HELPFUL SPIRIT
OUR POINT OF VIEW

Chances are that you or someone close to you is going to need medical care in the next few years. But, even if you do not need so much as a flu shot or a bandage, you may be paying for or helping to pay for the bills of people who do.

Good afternoon! My name is Jerry Campbell and I am the Administrator of Johnson County Regional Hospital in Clarksville, Arkansas. I am proud to live in a country and be represented by a Senator where people, government, and issues can come together usefully and freely. And, I thank you for this opportunity.

Much more important than this meeting is the plight of our hospitals and we should celebrate our ability to address our problems and solve them.

Nationally, health care expenditures take up 11% of our gross national product, or nearly $500 billion a year. Thirty percent (30%) of that total is public money that pays for government-sponsored programs.

The hospitals that I represent came together last week and agreed that what we needed to do today was focus on a few issues that if we address well in our government will give us the most outstanding results. The issues that we have identified are:

1. Inadequate reimbursement
2. Poor definition of the issues
3. Manpower recruitment & retention
4. Primary care in rural areas
5. Long term care

Senator Pryor, our hospitals want few things, but these things we must insist upon to survive.

As we address these issues, let us first ask ourselves some hard questions:

1. Does Congress intend for HCFA to drive rural hospitals out of business?
2. Does Congress intend that we spend more Federal money on the sewers in Cairo than on health care delivery in the State of Arkansas?
3. Does Congress intend that small hospitals are disproportionately impacted under Medicare's cost containment initiatives?
4. Is Congress aware that legislation that was designed to speed up Medicare payments was, in fact, implemented in such a way to have the net effect of significantly slowing down Medicare and Medicaid payments?
5. Is Congress aware that the wage index component actually has the impact of exaggerating the maldistribution of family practitioners and medical personnel?
6. And, finally, is Congress sensitive to how totally insecure our voting population feels about the continued access and quality of our health care delivery system?

In this era of Grahamm-Rudman/Hollings, it is important that the money we spend for health care not be too little, too much, or tied to unuseful or inaccurate assessments. I believe that we are here today because we know that the system cannot remain unchallenged or unchanged. Thirty-seven million Americans have no health care coverage at all. Another million become impoverished every year as they try to pay for extended care, which costs on the average of $22,000.00 per year. But, remember, that over 60 million people live in rural America.

In the mid 1960's, under the administration of Presidents Kennedy and Johnson, legislation promised the elderly that Social Security would be extended to include complete medical care for the aged. The population was growing and prosperity was all around. Those who were in their 50's or early 60's sighed a breath of relief that could be heard across the country. These men and women, knowing that they would not have to save for their health care in their retirement, freed up these funds from their savings to spend more on the college education of their children and for equipment and supplies to improve their farms.

But, since then, the population growth leveled off and the percentage of people in retirement relative to the number of people who are working has increased ahead of the plan. Interest rates available on savings have diminished and other rules, those from Baltimore, have changed.

Today, hundreds of thousands of retired people are living on the thread of unkept promises because of the change in these rules. Arkansas, second only to Florida in the number of retired people per capita, is at the same time at the bottom of the charts for the amount of dollars being spent per patient day, the number of beds available per capita, and the participation of the State in Medicare and Medicaid programs.

What does this mean? This means that when experts predict that 2,000 hospitals across the United States will go out of business, they are talking about Arkansas; they are talking about Mississippi; they are talking about Louisiana; they are talking about Texas. Yes, the evidence is already in. Recently, twenty (20) hospitals in Texas closed, eight (8) in Arkansas.

About 700 of 5,700 hospitals in the United States will close by 1995, according to a recent report by Arthur Anderson & Co., the accounting firm, and the American College of Healthcare Executives. The most endangered species: small, rural, county-owned hospitals like mine.

Now, William Roper, the head of the U.S. Health Care Financing Administration, says that the nation is "wringing excess capacity out of the system". Like Mr. Califano years ago, Mr. Roper confuses the size of the hospital and the fact that it is rural with the idea that the national objective ought to be to have an efficient health care system. The reality is that my hospital and the other hospitals that I represent today have extremely large service areas that include National Forests, mountain ranges, and the kinds of environment that people like and seek when they choose to retire.

I would like to suggest today that Washington's definition of efficiency should not be confused with the needs of the citizens of our State of Arkansas. Our citizens should not have to drive thirty to one hundred miles to get to a hospital.

Hospitals do more for the towns in Arkansas than just provide health care. They provide community services; they provide educational opportunities; and they help every community meet that definition of completeness that helps attract industry and potential employers. Most of the hospitals that

I represent today are league leaders in terms of the numbers of employees that they have, the average salary for that community, and the average total payroll for that community.

Many of our picturesque valleys and forests are underserved by primary care physicians. Our population would be even more drastically underserved if we did not have hospitals that helped attract new medical talent.

While Dr. Roper points to a national over supply of hospital beds and mumbles about a buyer's market, the reality away from Washington is that this is really an issue of poor distribution.

Nearly half of the nation's hospitals lost money treating Medicare patients last year, and many of the financially battered smaller hospitals in rural areas are in danger of shutting down, Federal officials reported at the first of this month.

"Some of these hospitals cannot provide much better care than a first aide station" and should be closed for both poor service and financial problems, Richard P. Kusserow, Inspector General of the Department of Health and Human Services, told a House Budget Committee task force.

While Congress does not intend to harm hospitals, Congressional efforts to control spending for Medicare have cut steadily into hospital profit margins, Kusserow and other officials said. Some forty-three percent (43%) of the hospitals lost money on their Medicare admissions during Fiscal 1987.

PRO performances are measured by the percentage of cases reviewed. Their performance and their rate of pay is higher for 100% review of hospitals. So, the PRO tends to review smaller hospitals more often than larger hospitals. Their marching orders: reduce admissions. Net effect: rural hospitals have a higher percentage of reviews even though this brings the least dollar effect.

Directives and instructions from Washington, directives and instructions from Baltimore, directives and instructions from the Medicare intermediary in Little Rock, directives and instructions from the PRO in Fort Smith, and directives and instructions from the HCFA Regional Office in Dallas lead me tc suggest that ALL hospitals are expected to have significant expertise inside the hospital; but a lot of the hospitals in our part of the state are too small to have this kind of staff and three or four DRG coordinators. Knowing this, the rural hospitals become the path of least resistance for PRO's and Medicare intermediaries. Again, the net effect is that rural hospitals have a greater percentage of the attention even though this yields the least dollar effect.

Retrospective denials have an impact on our doctors as well. When doctors find out ninety (90) days, six (6) months, or even years after a case that someone in a glass office building a hundred miles away has decided that they have changed their minds about the payment for a case and are now withholding dollars, they are driven to avoid Medicare rather than risk coming under 100% review. This disenchants the physician and it repulses new doctors from the area. The net result: quality goes down, access goes down. Patients are being undertreated in Arkansas and while HCFA does not intend to put hospitals out of business, that is the net effect.

The $540.00 a year deductible was originally based on cost per patient day with a fixed volume. When we changed from fixed volume cost to cost per case, the formula for establishing the deductible was not changed and we believe that this requires scrutiny.

PPS was originally designed to be a volume related way to cover costs. The desired effect was for the volume to go down and it did. The difficulty is that when the volume went down the contribution of fixed costs caused the cost per case to go up and this situation was exacerbated by not only denials, but retroactive denials. (What percent of costs were retroactively denied?)

Doctors avoiding the possibility of a denial delay the admission of a patient. The patient becomes sicker and, if still alive in time to get to a hospital later on, now needs treatment that is more intense, more expensive than the DRG originally had to allow.

In nursing homes, the decision to pursue hospital care for nursing home residents is delayed. Do we know to what degree this has impacted the increase in deaths in rural Arkansas?

COBRA legislation compels that hospitals pay $35 to $45 an hour for ER physician coverage. Region by region, hospital based physician fees are higher in rural areas where the supplements to income are needed to attract physicians. We must break some cycles. The program can only continue if it is driven by volume issues, not by fees paid.

Congratulations to Grahamm-Rudman! Retroactive reductions to capital reimbursement meant that what was billed as a 6% increase in contribution to operating costs was really a 4% reduction, partially because of a 2.2% decrease in PPS.

Our intermediary's evaluations are based on the dollars saved as a percentage over costs of recovery. This creates an auditing problem and raises the question of what our intermediary's costs are per claims processed. Right now, the motivation is to keep cases on six, seven, and eight year old appeals. Where are the resources and the manpower for small hospitals to fight these IRS-style reviews?

In Arkansas, sixty percent (60%) of the denials for Medicaid benefits are for technical, not qualification reasons. And, the State of Arkansas could attract far more federal dollars into the Medicaid program if it complied with minimum requirements.

Issue, manpower. The recruitment and retention of technical personnel, not just nurses, into the rural areas is hard to find when we are being allowed only seventy-nine percent (79%) of the national average for the federal wage index factor across the board in Arkansas. Remember, that the rural hospital has to compete with the large cities for technical personnel. They are trained in the city and they are paid in the city and will not leave the city to go to the rural hospital for a cut in pay.

Capital costs are actually higher, not lower, in smaller hospitals. The equipment that would work for twenty-four (24) hours a day in a major teaching hospital may only work for four (4) hours a day in a rural hospital. So, the cost of that equipment per patient is much higher.

RECOMMENDATIONS

Today, I invoke you to take heed, think wisely, and commit to the success of care givers throughout the fields and valleys of Arkansas and these United States. Those few areas of the total picture where we believe that, together, we have the opportunity for the most outstanding results are as follows:

1. STUDY FOR OBJECTIVE UNDERSTANDING THE WORK METHODS, EVALUATION METHODS, AND PAYMENTS TO THE PEER REVIEW ORGANIZATIONS AND THE MEDICARE/ MEDICAID INTERMEDIARIES TO GUARANTEE REINFORCEMENT OF CONGRESSIONAL INTENT AND ACCESS TO QUALITY CARE TO WHICH OUR GOVERNMENT HAS BEEN COMMITTED FOR A QUARTER OF A CENTURY.
2. REVIEW THOSE SAME COSTS AND METHODS OF INTERMEDIARY CONTRACTORS TO ASSURE APPROPRIATENESS AND SCALE EQUITY. STUDY THE POSSIBILITY OF A SEPARATE SYSTEM FOR HOSPITALS OF 100 OR LESS BEDS IF THEY ARE CARRYING THE SOLE PROVIDER DEMANDS AND RESPONSIBILITIES OF A SIGNIFICANT GEOGRAPHICAL SERVICE AREA.
3. GIVE YOUR ATTENTION AND UNDERSTANDING TO THE FROST REPORT FOR THE ARKANSAS HOSPITAL ASSOCIATION ON THE EFFECT OF MEDICARE AND MEDICAID ON ARKANSAS HOSPITALS.
4. PROMOTE PROGRAMS, PAYMENTS, AND EVALUATIONS THAT YIELD COST EFFECTIVE WAYS TO DELIVERY MENTAL HEALTH, CHEMICAL DEPENDENCY, AND SMOKING CESSATION CARE.
5. DELETE VARIANCES FROM THE WAGE-INDEX COMPONENT THAT HAVE THE EFFECT OF KEEPING TALENT AND DOCTORS OUT OF ARKANSAS AND PROMOTE PROGRAMS TO ATTRACT PRIMARY CARE PHYSICIANS AND TECHNICAL PERSONNEL TO ARKANSAS.
6. REVIEW THE ORIGINAL BASIS AND INTENT OF THE MEDICARE DEDUCTIBLE. WHICH COSTS MORE, PARTICIPATING IN REDUCING THAT DEDUCTIBLE OR TREATING THE DELAYED GERIATRIC PATIENT?
7. SEND A CLEAR MESSAGE TO HCFA, CONGRESS, AND THE WHITE HOUSE THAT CARE GIVERS CANNOT BE ABUSED INDEFINITELY; THAT SOME OF THE HARM WE DO TODAY IS PERMANENT.

BEST VISION FOR THE FUTURE

In my best vision for the future, the United States will continue to prosper and the population will continue to age. There will be more people living, there will be more people driving cars and skiing, and the demand for health care delivery services will increase. But, because of the questions that you are asking today, we will stop spending more money on the sewers of Egypt and projects we can no longer afford and get back to the basic needs of those around us. We will have the courage to review the commitments we have made and live by them. And, we will resolve the inequities and renew the partnerships between health care payers and health care providers.

Senator **Pryor**. Thank you very much, Jerry. That was well done.

By the way, if any of you in the audience want to express your pleasure or displeasure at any of us who are occupying these front row seats, feel free to do so.

Now, here is a man who's looking for a job as of last Friday—Mr. Franklin Montgomery, administrator, formerly I should say of the Lee Memorial Hospital in Marianna. Franklin, you have the floor and we want you to tell us what went wrong.

STATEMENT OF FRANKLIN MONTGOMERY, FORMER ADMINISTRATOR OF LEE MEMORIAL HOSPITAL, MARIANNA, AR

Mr. **Montgomery**. Senator, you've certainly picked a strange time to encourage people to show displeasure. I don't know if this was indicated or not.

I appreciate the opportunity to be——

Senator **Pryor**. I'm so used to it. I just wanted y'all to get used to it. [Laughter.]

Mr. **Montgomery**. Just pass it on. Sure.

I appreciate the opportunity to be temporarily resurrected so that I can tell the committee a horror story on what happens to a hospital and how it dies. I think it will become more evident as we go through more and more of the committee that many of these, most of these, problems are the same no matter whether you are a large hospital or a small hospital.

I would like to tell you about Lee County and how it grew and how it declined as far as medical care. Lee County, of which Marianna is the county seat, is classified as one of the 10 most poverty-ridden counties in the Nation. The county is typical of areas that have seen the decline of agriculture and force younger people to move to other areas for better jobs or jobs at all. This has meant the county has declined in population, and those remaining have evolved into an ever-increasing percentage of older people, with little or no opportunity for employment at all. Lee County, as we see with many of our rural counties, now has less than one-half of the population that it did in 1930.

Lee Memorial Hospital was constructed in 1957, during the heyday of the Hill-Burton Act. At this time, the county had six private practitioners, and the hospital prospered and grew to a point that expansion was needed in 1976. Medicare, meantime, came upon the scene and was a blessing to the already aging population. The Medicare patient was admitted to the hospital, was treated and made well, was released, and the doctors and hospital billed Medicare and they were paid in full.

Then, through either need or greed—one or the other, or maybe a combination—doctors and hospitals began an extended period of escalation of charges until Medicare responded by reducing payments by percentages and finally capped the charges accepted for procedures. At some point in this time, a decision was reached to pay a differential to rural and metropolitan hospitals based upon a study that proclaimed the cost of keeping a patient in a metro hospital was actually higher than keeping it in a rural hospital. The end line, of course, has been said several times—and I'm sure will be repeated—is that rural hospitals in Lee Memorial's classification collect only about 36 percent of the amount authorized to be billed, and metropolitan hospitals, such as Memphis or Little Rock, only 50 miles away to Memphis, can be paid up to 85 percent of that cost.

Detailed and accurate findings now reveal, as was indicated awhile ago, that the cost per patient is actually lower at a metro hospital than a rural hospital. Then came the DRG; we started to play alphabet soup. The Diagnosis Related Group, or in terms that us lay persons might comprehend, the days required to get well: "You will get well in so many days, or otherwise." A patient was classified as to need upon admission, according to an average developed by "Big Brother" or somebody. When the allocation or the allocated time was up, payment stopped. Unfortunately, this average was truly an average overall. And we find that when we are dealing with a county like Lee County and the hospitals in areas that have such a high aged population, the high side, not the low side of the median, is the average time when people get well or takes to get well. Also, many elderly admissions have underlying medical problems that surface during the term of hospitalization that require very expensive and very lengthy diagnosis and treatment, and physicians hold these patients far beyond the DRG expiration date. The hospital, though, is locked into the original DRG for weeks and even months sometimes, during which the hospital can collect no added reimbursement for the cost that has been incurred.

Meantime, back in Lee County, the six private physicians that were on board when the county hospital was formed in 1957 have gone by the wayside through death, retirement, moved away, and various things. We have been replaced by now one private practitioner that admits to the hospital.

A Public Health Service organization, the Lee County Cooperative Clinic, now serves the county with a staff of three doctors. However they are hired to basically work a fixed workday schedule that leaves the county exposed during nights and weekends. Also the clinic is limited in some areas to treating limited segments of the general population.

Now that Lee Memorial Hospital is closed, the nearest hospital is located over 20 miles from Marianna, and transportation alone for many is virtually impossible. If we can't run a hospital, we're going to end up running a very high-priced taxi service sooner or later.

While the complete and final resolution of this catastrophic and nationwide problem lies in lengthy legislative correction, there are three areas that can give immediate relief to the surviving rural hospitals that can transpire with simple changes of regulations or rules of operation:

The first, of course, has been stated time and again and will be through the day, is the absolute requirement to equalize Medicare payments to pay equal amounts to all hospitals for like procedures.

The second is to allow doctors to request and be granted, when justified, extensions in DRG days so that elderly patients may obtain total diagnosis and treatment and hospitals will be fairly reimbursed.

The third is to require that area health education centers [AHEC's] assign each and every county at least one medical graduate during residency training. Many AHEC residents find assignment locations to their liking and decide to practice there after they have finished their training period. There are many rural hospitals and medical societies that don't even know that AHEC's exist. Long-range relief, then, can be studied in more depth without the immediate and terminal jeopardy facing so many institutions today. Blue ribbon committees may plan well, but difficulties in timing and snails pace legislation may well turn such into redtape groupies. Immediate timely action is all that can assure our elderly and poverty stricken that they have a chance of survival to again become healthy and productive citizens.

In summary, relief must be achieved by expeditious means if we do not want to see our elderly population committed to what might be seen as a science fiction operation that plans and carries out eradication of an age and economic social group.

Thank you. [Applause.]

Senator PRYOR. I want to thank you, Franklin. Thank you very much.

Now, I'm going to ask you two or three questions here. One, Franklin, during the time that the Marianna Hospital was getting into trouble and more and more trouble, I assume there was a time when you sensed—maybe 1 year ago, maybe 2 years ago, maybe longer than that—that this particular institution was getting into trouble, that someday it might be closed; and my question is this: Was there anyone from the Federal level or anyone from the State level, any agency or entity of our government, that came there and said, "OK, we want to help. Here's what we can do if you do this." Was there anyone who did that?

Mr. MONTGOMERY. No.

Senator PRYOR. All right.

Mr. MONTGOMERY. That was simple.

Senator PRYOR. What role did HCFA play during the demise of the Lee County—Tell them in a moment——

Mr. MONTGOMERY. Who is HCFA? [Laughter.]

Senator PRYOR. All right. Tell them in a moment who HCFA is. I know who HCFA is, but——

Mr. MONTGOMERY. OK.

Senator PRYOR. You or Jerry, either one; you both mentioned it, and Roger did.

Mr. MONTGOMERY. Jerry, you tell them who HCFA is. You——

Senator PRYOR. Don't tell them all you know about it, just what it stands for and what it was supposed to do.

Mr. MONTGOMERY. Oh, no.

Mr. CAMPBELL. I think that this is one of those situations where to get the best answer, I will follow up with a letter to you in 4 or 5 days. All right? [Laughter.]

But the Health Care Financing Administration is that agency headquartered in and around Baltimore, I believe, close to Washington, that oversees the policies and the execution of congressional intent with varying degrees of accuracy and says how much hospitals will be paid for that amount of participation in Medicare and Medicaid care delivered. I'll stop at that for today.

Senator PRYOR. All right. Did anyone—did HCFA come and see you and want to help, Franklin?

Mr. MONTGOMERY. No; they did not. We did not hear from HCFA.

Senator PRYOR. Anyone on the State level?

Mr. MONTGOMERY. No; the State level—at all agency levels in the State, they were very cooperative.

Senator PRYOR. Yes.

Mr. MONTGOMERY. But nobody had any answers.

Senator PRYOR. Right.

Mr. MONTGOMERY. I really think that they did all that they could, but the answers just weren't there.

Senator PRYOR. I think within each hospital in a emergency situation—what is it, code blue?—and you have a team that comes in. Seems like we need a team to come in and help with some of these troubled hospitals. I've not seen this, and I'm not in any way disparaging what is happening on the State level; I am concerned about the Federal level.

All of our well-meaning legislation sometimes does not really hit the mark, and many, many times we make a mistake. We've just passed a very controversial piece of legislation—catastrophic health insurance. I'm not so sure that, and even though I voted for it and supported it and saw its need, I'm not so sure that it's 100 percent perfect. We may have to go back and revisit it. I know in 1986, I hate to admit this, but I voted for a major tax reform measure that we thought was going to be simple and easy and fair. Well, it was none of the three, and so we're going to have to go back and look at that. Our system is pretty imperfect sometimes. When we look at this reimbursement, when we look at Medicare and Medicaid, when we look at what we have to do in 1989 and 1990, we're trying to keep from making mistakes, and that's why we're holding these hearings.

Now, all three of you gentlemen were very eloquent. Let me ask this: Do any of you know, and we've got some doctors coming up in a moment and I may ask them this question. I was just looking at our State map. If we look up there in Baxter County, we'll see that Baxter County has about 30 percent of its population over—that's Mountain Home—over 65. That's probably one of the highest counties in the State, and that's up in the mountains. There's a lot of retirees there, a lot of settlers there who just don't want to leave and never will leave. In Jefferson County, where we are, we have about 13 percent elderly.

If you are an ophthalmologist in Baxter County doing cataract operations, you're getting reimbursed by Medicare, I think, about 50 percent, or maybe not quite that much variance, about 50 percent of what you would get for that same operation, same hospital time, let's say, in Chicago or San Francisco or even up the road in St. Louis. So, we can see how this is really damaging in enticing physicians to come to some of the rural areas of this State and the rural areas across America.

Now, are there any final remarks any of y'all want to make? I want to ask Dr. Elders if she has any questions of this panel or if y'all have any questions of Dr. Elders. This would be a good time to exchange if you have that.

Dr. ELDERS. No; I have no specific questions. I think Dr. Busfield and I talk very frequently, and we try and work out and iron out problems.

Senator PRYOR. Now, do you—are you getting good cooperation from all of the people that they represent?

Dr. ELDERS. Yes.

Senator PRYOR. And are y'all getting good cooperation from the State Health Department? [Affirmative nods from the panel.] Good. Now, the one that they're not getting cooperation from is the Federal Government that I am representing. [Laughter.] So, with that we will move on to our third panel. We thank you very, very much. Let's give both of these panels a nice hand. [Applause.]

Ladies and gentlemen, we've been here now about 1 hour and 20 minutes. We're going to take a 5-minute break, and we'll see you back here in 5 minutes.

Hearing reconvened at 3:05 p.m.

Senator PRYOR. Let's see, I believe that we need Judge Tom Catlett. Now, where is Judge Catlett? Here he is. Tom, you come right up here. And, then, also Ms. Mary O'Rourke. She's right here. Thank you for coming.

We're going to have both of our panels sitting simultaneously once again, and we appreciate the attendance.

Let me first tell you about our first witness and that is Mary O'Rourke from DeValls Bluff. Ms. O'Rourke is a retired schoolteacher. And I guess it's all right, Mary, if I tell them your age. My little fact statement says that you are 82. You taught in the public schools for 35 years. Channel 4 recently honored this wonderful witness as making her the Volunteer of the Year and presented her an award for that achievement. And she's going to talk this afternoon about two issues. One is the manpower or womanpower shortage and the hospital reimbursement system.

Then we have the Monroe County Judge, Judge Tom Catlett. And, Judge, I may be wrong, but I think you're probably the senior in terms of service of all the county judges in the State at this time. So, we look forward to your statement also. He's the president of the Mid-Delta Rural Health Clinic there in Monroe County, and he's quite active with the Central Arkansas Area Agency on Aging.

Mary O'Rourke, we look forward to your statement.

STATEMENT BY MARY O'ROURKE, PRESIDENT OF THE CENTRAL ARKANSAS AREA AGENCY ON AGING, DEVALLS BLUFF, AR

Ms. O'ROURKE. Senator Pryor, thank you for coming home to find out about our problems. You've already heard many of them before I get to mine, but if I repeat myself it's because we really are in trouble.

We do know that these problems exist in other areas besides our own. We're not sure how all of these may be taken care of, but there are a few things that I know that we can do to begin to change the health care policies that are affecting rural health care.

Senator Pryor, I'm not that old; I just don't see very well. [Laughter.]

Senator PRYOR. You're doing fine. Thank you.

Ms. O'ROURKE. One of the problems in Prairie County, which is a very rural county, is one that's already been discussed The major health problem here is getting doctors and keeping them. We were without a doctor in DeValls Bluff from 1965 to 1986. For 21 years, we had no doctor. During that time, I saw a Dr. Williams in Brinkley. After his death, I had to seek medical care other than in this rural community where I lived I sought medical care in Little Rock.

By that time, the Brinkley Hospital had also closed, and the people in the DeValls Bluff area must use either the Stuttgart hospital or the North Little Rock Hospital. Having the DeValls Bluff Clinic open as a satellite of the Mid-Delta Rural Health Center in 1986, brought physician service back into our rural town. We appreciate having that clinic, and it took an awful lot of work and an awful lot of people to get that done. And I'm going to say that Judge Catlett really helped us with that problem.

Now, the solution might be, as a part of this solution to getting and keeping doctors practicing in our rural communities, I support the community health centers. I hope you will see that they continue, and that it is funded at levels which are adequate to continue current services as well as to go into other services. Some of the rural health clinics are operating on such tight budgets that hours of operation are severely restricted. It would be great if our clinics could offer weekend services or emergencies.

Often the doctors in the rural communities die, and that's what happened. Ours was a family group, and when the last one died, we just lost doctors. There is no one to continue their practice. That is how DeValls Bluff and several other small towns in our area came to be without a doctor.

Give the young doctors incentives to practice in rural areas. Continue the National Health Service Program; in fact, increase it. I have heard that it may be discarded. Until the disparity in the rural and urban health care is changed, I support the National Health Service and other programs like it that ensure rural health care.

Another problem is the reimbursement policy which has already been discussed pretty fully, especially the Medicare prospective payment system. They are biased against rural health care.

Thank you.

Judge CATLETT. Are you through?

Ms. O'ROURKE. No, I'm not.

Hospitals are closing at an alarming rate. Fifteen rural Arkansas hospitals are on the brink of closing their doors now, and we've already heard that many of them have been closed. When these hospitals close, the doctors usually move to be close to other hospitals. Jobs are lost. Health care is totally compromised. In fact, if you look at almost every major public policy issue in this country today from the economy to health care, you might be led to believe that there is a big conspiracy against the rural areas, but we know that there is no such conspiracy. What has really happened is that the policy decisions have been made without regard to how they will impact the rural areas. I don't imagine anyone had any idea how severely the rural health care would suffer from the lower Medicare reimbursement rates. But look at the results: Many Arkansas communities are losing their hospitals and their doctors.

As a solution, equalize the reimbursement for health care services whether it's rural or urban. Make sure that every national policy is scrutinized in terms of its potential impact on rural health care.

Another problem we have in our area is getting to the doctors. Getting to a source of specialized health care such as to the Central Arkansas Radiation Therapy Institute, or CARTI as we know it, or getting to the hospital for emergency care, or just getting to the hospital can really cause problems. Medical transportation and ambulance services are critically inadequate. It's disgraceful that a terminally ill person has to beg someone to take them to CARTI. Access to good, affordable health care is a basic human right, whether you live in town or in the country.

We suggest that you fund the medical transportation and ambulance services to the rural areas to assure access to the needed care.

In summarizing these needs:

First, getting and keeping the doctors practicing in the rural areas.

Second, reimbursing the urban and rural health care providers at equitable rates.

Third, reviewing all proposed policies in terms of their potential impact on the rural areas.

Fourth, providing appropriate medical transportation and ambulance services.

We have heard that this country has been in danger of having a two-tiered health care system. Frankly, that has inadvertently happened. Our urban citizens have far better access to quality care at affordable rates than do their rural counterparts. I commend you for holding this hearing on rural health care. Now you have heard what our problems are, and I feel very strongly about it. We know that you're our friend and that you would do anything to help us. We're asking you to see that these problems are presented to the proper source and to be resolved as quickly as possible.

Thank you. [Applause.]

Senator PRYOR. I want to thank you, Ms. O'Rourke.

What happens to a person in DeValls Bluff tonight at midnight if they have a stroke or a heart attack? How far is it to the nearest physician?

Ms. O'ROURKE. There is a physician 7 miles from us in Hazen who is ill and who practices not full time at all. They do have ambulance services out of Hazen, but you can't always get them. And so, there is where we have to have somebody to take them. And the fire department sometimes helps us out on problems like that. But there's no ambulance service in our town at all.

Senator PRYOR. So, if the physician were ill some miles away and you could not get the ambulance service and the fire station didn't answer the phone, you'd just be stuck?

Ms. O'ROURKE. We would be stuck.

Senator PRYOR. Unless you had a friend or relative or some of your kinfolks or neighbor to drive you?

Ms. O'ROURKE. That's true, Senator. And they usually take them to Stuttgart which is about 25 miles or they bring them them over here to Little Rock which, of course, is 50 miles. And you can't always get anybody, because our telephone service is not all that good sometimes too. [Laughter.]

Senator PRYOR. I was negligent in getting this hearing together in our witness list, because there are some segments of this whole delivery system that we have not included. One of those is that group representing the ambulance services. There are several of those out here, and I'm going to ask them in a moment when we conclude our fifth panel, I'm going to ask them to step up to this microphone and sort of tell their side of the story. We want to get a picture of as much as possible of this entire puzzle, as much as we can.

Ms. O'ROURKE. Well, we're really in trouble in that transportation area, because unless you know somebody that will, that you can call on personally, you just may not get to the doctor in time.

Senator PRYOR. I sure thank you for your statement. We may have some other questions.

Judge Catlett.

STATEMENT OF JUDGE TOM CATLETT, MONROE COUNTY JUDGE, PRESIDENT, MID-DELTA RURAL HEALTH CLINIC, CLARENDON, AR

Judge CATLETT. Thank you, Senator Pryor.

First of all, I want to thank you for what you have done for the senior citizens of America and Arkansas since you have been in Congress, even back when you were Governor. You know, we go back a pretty good ways. This is my 22d year as county judge. I've been through six Governors, I believe. But anyway, this is one of the finest Governors the State of Arkansas ever had.

Senator PRYOR. Thank you. You can talk all you want to, Judge Catlett. [Laughter.] Thank you, Tom.

Judge CATLETT. But this is the most critical thing that I have seen in my tenure as Monroe County Judge is the problem that we have with the rural health care. All of it has already been said that I have to say. I have a statement; the Senator has a statement of it now. I'm not going to read it; I'll just tell you a few things. Mr. Montgomery from Lee County, he's said it about all; we're neighbors.

Our hospital at Brinkley was closed about 1½ years ago, and most of the physicians that were there, not the old established physicians, some of them are there and some of them have died, but the ones that came in due to the new ownership of the hospital, they left with the hospital. Well, certainly, that was a great loss to us. We are a sparsely populated county of 14,000. We're in the Mississippi Delta. We're in a farming area—cotton and soybeans and so on like that. Our younger folks have to leave the county, the majority of them, to find jobs. And our elderly people are scattered throughout the county.

The way I see this is that the people that made America and the people that stood for what America was based on are the ones that getting penalized. Because they have no, when I say "no," I mean I think they should have 100 percent—I'm speaking of our elderly, now they should be taken care of. I think whatever it takes to take care of the people that made our country, we should do it regardless of the costs. Now, you might not agree with me, but they made us and we should take care of them. That's how I believe about the elderly and needy. Now, these people that just halfway need it, now, I'm not for that. God forbid that I ever will be. And we have a lot of that too.

But our county is like every other area that these people have talked about. Our people need help. I'm speaking of our elderly people in rural areas, and Monroe County is a rural county. In fact, rural counties in rural America make up America. There's more rural in our county than there are urban.

Maybe I haven't said the things that you wanted to hear, but I believe in what Senator Pryor is doing for us. I want to compliment the Area Office on Aging, our public health department, Arkansas Public Health Department, for what they are doing and have done for the elderly people for the State of Arkansas.

Thank you, Senator. [Applause.]

[The prepared statement of Judge Catlett follows:]

TESTIMONY OF HON. TOM CATLETT
MONROE COUNTY JUDGE
for
U.S.SENATOR DAVID PRYOR

Thank you, Sen. Pryor. I am happy to be here today.

I am concerned about a number of national policies that are having startling negative effects on the rural areas of our state. You are familiar with Monroe County where we raise a lot of soybeans in rich Mississippi Delta soil.

Unfortunately, most of our young people leave Monroe County to make a life for themselves elsewhere. Though sparsely populated, Monroe County has a rather high percentage of older citizens. We also have a significant minority (black) population like most east Arkansas counties. For the most part, annual incomes are low to modest.

Right now, we have no hospital. The hospital at Brinkley closed. When that happened the dozen or so doctors in Monroe County who used the Brinkley hospital left the area. I feel it is unlikely another hospital will ever open in Monroe County again.

The Public Health Department offers no primary health care, mainly family planning and immunizations. We appreciate what they do, but, primary care is greatly needed.

With the only hospital and most of our physicians gone, we have had a hard time having rural health care available. When the government recognized that we were a medically underserved area and funded the Mid-Delta Rural Health Clinic at Clarendon in 1979, things began to change. Though better because of the Rural Health Clinic, all of our problems are not resolved.

The Center is chronically underfunded. It needs about $60,000 or $70,000 more per year just to do a fairly good job of the work it now has to do. The best thing that could happen is that the Center could get enough money to meet its current budget and to expand services.

The rural health center is important. We want to keep this program. It is often the only source of health care for many of our residents.

Hospital care is available from Stuttgart or Forrest City. Ambulance service and just routine medical transportation are hard to get if you live in Monroe County and you don't have a car or can't drive. Many of our older people can't drive, for one reason or another, to the medical services they need. We need more public transportation under UMTA, Section 18.

Our people say they have trouble seeing a doctor or going to the hospital because they lack the money, they lack the transportation, or there is no doctor or hospital close enough, or if there is, the health care provider won't take Medicare or Medicaid because the reimbursements are far too low.

Just fun[illegible] community health centers isn't really enough. They need help in finding new ways that work to attract physicians, dentists and allied health care professionals. Mid-Delta Rural Health Center has been looking for a dental hygienist now for well over three months with no known prospects at this time.

For now, the National Health Service needs to be continued. Some of the physicians assigned to rural areas really find they like it and want to stay on with us when their commitment ends. Others prefer to pay high penalties to get back to the urban areas as quickly as possible, but, at least we were able to benefit from them while they were with us.

Medical transportation and ambulance service needs to be available in rural areas in adequate supply.

The only other big point I would like to make is that I hope the federal government will make it a standard operating procedure to carefully review every health care rule that you plan to make before it becomes a rule in terms of what it will do to rural health care.

From the standpoints of access, quality and costs, rural health care is in trouble. Senator, I don't know all the answers. I do know this. It is time for Congress to make sure that the citizens of rural America - - especially, Monroe County, Arkansas - - have adequate health care.

Senator PRYOR. Thank you, Judge.

Judge, is there anything that—I know how strapped—especially since you've lost your revenue sharing now, our cities, counties, and the local communities are for money. Is there anything that the county governments can be a part of, or that they can do that can help to resolve this situation, perhaps in transportation or perhaps in ambulance service? Is there anything else the county governments could do right now?

Judge CATLETT. Senator, I tell you. That's one thing that I forgot. That we have, I won't say that we have two ambulance services, there's two ambulance services that service Monroe County, and one of them is out of Forrest City which serves the northern part of our county, and the Stuttgart Hospital over to our west serves the southern part of our county. The cities in our county, with the help of the county, are subsidizing these ambulance services. I can say that we have a fair ambulance service.

I would say this, too, Triple A has been mighty nice to Monroe County. They furnish a medical car that don't very many counties get. That's under my supervision, and that's helped tremendously, Senator.

I don't know whether I—Then I might say this, too. I think we have two rural health physicians sitting there, I'm not sure. I think that, according to this list here, that's what there are. Now, we have a rural health clinic that was funded with Federal money. It was a grant through the FHA. Now, we pay that grant back, but we pay it back with Federal money, and it's been a tremendous help, and that's how we got to help the citizens of DeValls Bluff, the satellite from our clinic. But what has happened, Senator, the funds have been cut, and we don't, we lack $70,000 having enough this year to carry on the basic service that we need. So, where you cut, I don't know. But we saw the need to help our neighbor in DeValls Bluff, and we done it.

And there's good physicians that come from the National Health Corps Service, too. They're good physicians. The only thing, when they come here they might not like where they are. They might just be here because they're in the area that they have to put their time in to pay back their schooling. Nevertheless, we're happy that they stay as long as they do. They're good physicians; I want to emphasize that. I'd certainly hate to see anything happen to that or anything happen to our rural health clinic. Because without this rural health clinic, I don't really know what the people in the southern part of Monroe County would do, Senator.

Senator PRYOR. Judge Catlett, just for my own education, and I don't know each of the counties that have a sales tax, a local sales tax. Does your county of Monroe have a sales tax or is it one of——

Judge CATLETT. Senator, we have a sales tax. It was voted to build a detention center. We've built that center. It'll be about 2½ years before the bonds have retired, will retire, and then it goes off. Hopefully, though, the citizens of our county will vote it back in for the operation of services such as this and anything pertaining to the betterment of the county. We do have a sales tax, Senator, and we have just opened our detention center back in June. It's a nice one. I guess you'd call it a necessary evil. But anyway, we do have a sales tax to be used for that purpose, Senator.

Senator PRYOR. You have a fine jail, but you don't have a hospital. Is that what we're saying? [Laughter.]

Judge CATLETT. Have a fine jail and no hospital and really no provisions to, in other words, the additional costs it will be for this new detention center, there's no provisions for that, too. So, but that's one of those things. We were out of compliance, and we've been out of compliance as long as I can remember. It just come to the point that something had to be done. But the citizens of the county came to our rescue, and I believe they will do the same thing when it goes off, Senator.

Senator PRYOR. Well, Judge Catlett, we thank you. And if the two of you don't mind sitting for a moment, we may have another question or two after our next panel, or maybe y'all want to ask each other some questions. We want to thank you, Judge Catlett, and thank you, Ms. O'Rourke.

Now, Ms. O'Rourke, when she opened her statement, talked to some degree about the National Health Service Corps. We have two physicians here on our next panel. One of those physicians is Dr. DeWayne Nash. He's a former National Health Service Corps physician, a family practitioner in Camden, AR, in my hometown. Now, we also have Dr. Wayne Waller. He's the medical director of Jefferson Comprehensive Care Center, right here in Pine Bluff, current National Health Service Corps physician.

Now, one of these individuals has had a very good experience with the National Health Service Corps, and one of these doctors has not had a very good experience. And we're going to let you hear from them what's right or maybe what's wrong with this program. First, we'll call on Dr. Nash.

STATEMENT OF DR. DEWAYNE NASH, NATIONAL HEALTH CORPS PHYSICIAN, M & S CLINIC, CAMDEN, AR

Dr. NASH. I will speak on my experience as a National Health Service physician in Stephens, AR.

I am a board-certified family practitioner who has just recently completed a 3-year commitment to the National Health Service as a private practitioner in Stephens, AR. I've since moved my practice to Camden, AR, as of August of this year.

Stephens is a town of 1,300 people located approximately 19 miles from Camden which has a population of 15,000, 16 miles from Magnolia which has a population of 10,000, and 25 miles from El Dorado which has a population of approximately 25,000. It is primarily an old oil and timber town that has, as late as the 1960's, supported two physicians. It is composed of a lot of elderly people and a lot of indigent people. Those that live there who work now commute to either Magnolia, Camden, or El Dorado. Most of these commuters have lived in Stephens most of their lives. Few people have moved to Stephens in recent years.

When I completed my residency in family practice at the University Medical Center in Little Rock and began to look for a practice site to fulfill my 3-year commitment to the National Health Service, there were very few sites available in Arkansas. Stephens was an approved National Health Service site, but there was no real clinic available there. Since I grew up in the surrounding area, I felt like Stephens could support a private practice, and I wanted to stay in Arkansas. I then came to Stephens under the private practice option in which I bought the old Dr. Henry Hearnsberger Clinic, remodeled it and equipped it. I received very little help from the National Health Service, the State, or the Federal Government. I did establish my practice there in hopes that I could continue my practice there after my 3-year commitment was up. That has not happened.

In the first year I was there, the largest employer, Elk Roofing, closed. Approximately 125 people lost their jobs. Also, in that year, the oil prices dropped. A large number of people in Stephens lost their jobs, and a large number either were unable to pay bills or declared bankruptcy. These changes that occurred in the community, combined with the large number of indigent patients, Medicare patients, and Medicaid patients, made it very difficult for my practice to survive financially in Stephens. For every $1,000 in charges that I billed to Medicare and Medicaid, I received approximately $500 in payment and had to write off the other $500. Over 50 percent of my office visits were Medicare or Medicaid visits. Many practices can survive this type of heavy Medicare, Medicaid, or indigent practice by having a good private paying patient population. However, many of my private patients were unemployed or barely employed and unable to pay their medical bills.

I have now found it more economically feasible to move my practice to Camden, despite the large debt that I sustained, leaving a now vacant clinic in Stephens. I managed to survive my 3 years in Stephens financially but not without difficulty and not without a lot of stress on myself and my family. I sustained a large debt from my investment in Stephens that will take me years to pay off. My accountant, in doing my taxes last year, stated that his son who climbs light poles for AP&L made more money in a year than I made last year.

Now, I enjoyed practicing medicine in the rural community. The patients had a lot of respect for me, probably more so than I would have gotten in a much larger town such as Little Rock or Pine Bluff. And I feel like I was able to practice good medicine. I was well trained in residency and was able to care for most of the medical needs of my patients such that few people needed to leave town for their medical care.

What will happen to Stephens, AR, in the future is what will happen to the small rural communities of America in regards to their medical care, with the worst affected groups being, of course, the poor and the elderly.

Most of the communities the size of Stephens have a lot of poor and elderly patients. They are also the ones that are the greater utilizers of the medical system. However, they also have a much more difficult time in traveling the 15, the 30, the 40 miles to seek medical care. Many have to depend on someone else to take them to their medical services. Others find it very difficult to drive outside their small communities.

I've also noticed that fewer of my Stephens' patients have been coming in for routine health maintenance exams as before when I was in Stephens. I have also noticed that they're usually sicker when they do come in to see me now in Camden.

Similarly, the same payment mechanism for Medicare and Medicaid that affected me is affecting the rural hospitals. Now with the DRG payments from Medicare being lower for rural hospitals as compared to urban hospitals, many of the nearby rural community hospitals may have to close. A larger hospital in El Dorado, Pine Bluff, or Little Rock may get $3,300 DRG payment for someone with heart failure, and a rural hospital such as Camden or Magnolia will only get $1,900 for taking care of the same patients. This has been one of the reasons for the closing of hospitals in Gurdon, Lewisville, Marianna, McCrory; and it's just about closed the hospital in Prescott, AR.

Most patients in the rural hospitals are Medicare, Medicaid, or indigent patients, mainly because they get sicker more often than private payment patients. Also, many private payment patients tend to want to travel to larger communities because they feel that better care is given there, or that they have the exposure to specialists that the small rural hospitals do not have access to. I can tell you from my personal experience and from the experience of my patients that that is not necessarily the case. Usually, just as good care is provided in the rural hospitals and at a cheaper price as is provided in the large urban hospitals.

If the rural hospitals should close, you also usually lose the physician, the local pharmacist, and many of the ancillary medical services that are available. That's what is happening in Lewisville and Gurdon.

What can be done to save Stephens' medical services. A new physician could move to Stephens and set up his practice. That's unlikely to occur. The clinic could become a satellite clinic for one of the local hospitals. Nearby hospitals are already pressed financially, and this is unlikely to occur. The clinic could become a part of a community health system that's available in this area, and this is the most likely chance for recruitment of a physician or medical services to Stephens at this time. However, if the nearby hospitals do not survive, it's unlikely that any new medical services will ever be present in Stephens.

Thank you. [Applause.]

Senator PRYOR. I want to thank you, Dr. Nash. That was an eloquent statement.

Let me ask this before we move from Dr. Nash. You said that Stephens was one, and I'm very familiar with Stephens, being right there south of Camden, you said that Stephens was one of the very few certified or approved towns where you could go from the National Health Service Corps. How does a town get approval from the corps?

Dr. NASH. I'm really not sure.

Senator PRYOR. I'm not either. I never have——

Dr. NASH. Yeah. I know—I don't think the approval process exists anymore.

Senator PRYOR. We will have that made a part of the record. And once again, I'm trying to educate myself. We'll put something in the record and take that back to Washington.

[Subsequent to the hearing, the following information was received for the record:]

OVERVIEW

THE NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP PROGRAM

In 1972, the National Health Service Corps (NHSC) Scholarship program for medical students was initiated to help alleviate health manpower maldistribution problems in the United States. The program requires an equal number of years service in Public Health Service sites for each year of medical school tuition paid for by the NHSC. The preferred PHS sites are those in Federally designated Health Manpower Shortage Areas (HMSAs).

By 1978, approximately 3,000 NHSC scholarships had been awarded. During the Reagan Administration, the budget for the scholarship program was decreased dramatically. The program now offers only 10-40 scholarships per year. By 1990, the program will virtually cease to exist.

At present, 32 Corps physicians have been assigned to Arkansas. Only 7 or 8 will be left in the State by 1990.

Briefly, the steps for assignment of a Corps physician are as follows:

(1) Request is received by the State Health Department, which is then forwarded to the Dallas regional office of the Department of Health and Human Services.

(2) Based on a community's designation under the Federal Health Manpower Shortage area guidelines, State requests are prioritized.

(3) Eligible Corps physicians are then sent a list of available sites; however, the NHSC makes the final determination as to placement.

Senator **Pryor**. By the way, I've been remiss. The young lady whispering in my ear has come down to prepare this hearing, and that is Portia Mittelman. She's on our Washington staff, and she's done an absolutely super job in putting this together, and I want to thank Portia for that. She's not only a very efficient person but very caring, and she is an Arkansan from Little Rock. She's been with me now some years, and I'm very appreciative to her.

Our next witness on this panel is going to be Dr. Wayne Waller, the medical director of the Jefferson Comprehensive Care Center here in Pine Bluff. Dr. Waller, we appreciate you attending today. We look forward to your statement.

STATEMENT OF DR. WAYNE WALLER, MEDICAL DIRECTOR, JEFFERSON COMPREHENSIVE CARE CENTER, PINE BLUFF, AR

Dr. **Waller**. Senator Pryor and other members of the panel, I appreciate the opportunity to come before you today to discuss the problems involved in delivering health care in rural Arkansas. I am a board-certified family practitioner like Dr. Nash, and I've been the medical director of Jefferson Comprehensive Care Center, which is the local community health center in this area, for about 2½ years now.

During the 1970's, many programs were established to try to encourage physicians to enter rural practices. I personally am the result of several of these programs. I attended the University of Arkansas College of Medicine which has always had a strong emphasis on rural care. I joined the National Health Service Corps whose primary mission was to place physicians in rural settings or urban settings which had too few doctors to take care of the people. And I went through my family practice residency at the Area Health Education Center in Fayetteville, AR. The AHEC's were started in Arkansas and in several other States to encourage young doctors to enter practice away from metropolitan centers.

I'd like to depart from my prepared text for just a moment to comment on what Dr. Nash was talking about. He chose what was called the private practice option. That's where a doctor goes to a medically underserved area like Stephens and opens his clinic, and hangs up his shingle. If you make money, great. If you don't make money, well, too bad. You move on to somewhere else when your obligation is up. I was more fortunate. I found a situation here in my hometown of Pine Bluff with a community health center, what the Health Service Corps calls a private practice assignment. There's a big difference between a PPO and a PPA.

In my situation, I had to spend no money of my own. The government even moved me from Fayetteville to Pine Bluff. I walked, my first day, into a clinic that was fully equipped, and fully staffed; I already had patients on the appointment book, and I haven't looked back since then. It hasn't cost me a penny to enter practice in this town, and for that, I am grateful. I don't owe as much money as a lot of my colleagues did coming out of medical school, but it's quite a frightening prospect to think that "Hey, I owe $30,000 for going through medical school, and now I'm going to go borrow another $100,000 to open an office." I'm glad that was a decision that I did not have to make.

I was fortunate, more fortunate than a lot of Health Service Corps doctors are. I found a good program in a place I was familiar with, comfortable in living, and the fact is that it happened to be my home town which does not happen very often in the Health Service Corps. A lot of the physicians I have met who work in the other community health centers in Arkansas are frequently from other parts of the country. They have been more or less coerced into coming to Arkansas, because our need is so great and the need in their native areas is less so. The government has twisted their arms to have them come to this area. They've been good doctors. They've done good jobs in their communities. But let's face it: A doctor from Pennsylvania is much less likely to stay in DeValls Bluff or some of the other smaller towns served by community health centers than a native Arkansan would be.

What are the health care needs of these rural populations? We've heard many so far today. In our part of the State, most of the rural population seems to be black and poor. Many of these people suffer from chronic health diseases such as hypertension and diabetes. Many of these people have a serious problem with obesity due to poor nutrition. One in five live births in Arkansas is to a teenage mother. These problems frequently can be traced to the fact that most of these rural areas suffer from a lack of access to a health care provider. One of the causes which has been mentioned of rural hospital failure is the shortage of doctors to admit patients to them. Complications of high blood pressure and diabetes, due to poor control of the disorder, lead to heart disease, stroke, and premature death for too many of these people. Teenage pregnancy and perinatal complications can be related to the lack of adequate family planning counseling and prenatal care.

In spite of the efforts to encourage doctors to go to these rural areas, many physicians still prefer to cluster around the major metropolitan areas. They like the ready availability of the cultural and educational assets that a large city has. Frequently, these doctors can associate with other doctors or join large medical groups, saving the initial expense of starting a practice. Call coverage is easier in a large community, so the physician can have more time off. The opportunity for a higher income is also greater in a large medical community.

How can we overcome the advantages of city life? I believe one answer is with the rural community health center. By placing clinics in small rural towns near the patients who will use them, these centers can go a long way toward providing the services that these people need. Community health centers emphasize preventive care in the hope that hospitalizations can be minimized. Some centers, such as ours, can provide complete family planning, prenatal care, deliveries, and postpartum care in an effort to lower the perinatal mortality rate. Community health centers can provide disease prevention services, such as blood pressure screenings, cholesterol screenings, diabetes screenings, and vision screenings. They can establish education programs warning the public about the dangers of smoking, alcohol and drug abuse, obesity, and teenage pregnancy, just to name a few. Transportation services for those patients unable to get to the clinics on their own can be provided. Many people living in poverty in rural areas have no idea that they may be eligible for social programs or assistance. It is amazing how many people come to the clinic who do not realize that they are eligible for Medicare or Medicaid services. Frequently, the ones who do understand that they are eligible have no idea of what the benefits are. The community health center can employ a social worker who can work with these people to educate them about what they are eligible for and help them cut through some of the red tape to get the benefits that they are deserve. The center can also help these poor people through the use of a sliding fee scale, where the fee paid by the patient for services is dependent on the income of that patient.

That sounds like a lot for one place to offer, and it really is. But our center, Jefferson Comprehensive Care, can provide every one of these services. Most community health centers can offer a large percentage of these services. Over the last two decades, community health centers were started throughout the country and in Arkansas. There are now eight of these centers in Arkansas providing care to some of the most severely depressed areas of the State. In addition to our clinics, there are centers scattered through the east, southeast, and northeast areas of the State. The need for these clinics is great, and I believe they do a great job in meeting those needs.

However, community health centers are standing at a crossroads right now. In the past, the community health centers have depended on the National Health Service Corps to provide their physicians. Since it takes at least 7 years for a doctor to complete medical school and a family practice residency, the dramatic cuts in the National Health Service Corps funding of the early 1980's are now causing the supply of Corps doctors to dry up. This potentially can be a devastating blow to the community health center. A CHC has been able to pay its doctors less because the doctors were under an obligation to serve. Now that the supply of obligated doctors is almost gone, the community health center must improve its compensation package in order to stay in business. Otherwise, they may find themselves with very nice facilities and good services but no physicians.

I don't want to imply that money is the sole factor. Call coverage and preexisting facilities are very useful when it comes to recruiting doctors to these rural sites. As I mentioned before, many physicians prefer the larger cities for just those reasons. However, I've lately been active in trying to recruit new physicians for our center. I'm very aware of what many young doctors coming out of residency are looking for, and I am also aware that in the central Arkansas area there is about a $15,000 difference between what we can offer as a starting salary at our center and what a first-year guarantee for young family practitioner is in many of the larger medical areas in the central Arkansas area. The doctor in private practice or in a large group practice frequently will have his or her malpractice insurance and health insurance paid as a fringe benefit separate from his salary. Many community health center physicians have to pay for these expenses out of their pocket. That makes their actual compensation several thousand dollars less than the face value would seem.

This problem comes at a time when the grants from the Public Health Service that the community health center depends on have not been increasing. In our region, region VI, the total amount of money for all the community health centers in Arkansas, Oklahoma, Louisiana, Texas, and New Mexico has not increased in 2 years, yet the costs and expenses of running these community health centers has increased. Several centers in these five states have expanded their services significantly during this time period also. The increased grants to those centers to cover the increased services has caused the reduction in grants to some of the other community health centers. Our center, in their grant for this year, was, I believe, some $400,000 below the minimum we needed to maintain the same level of service that we offered last year. Some centers have had to cut back on the services they offer because of this. Other centers have had to lay off employees, and some have even had to close clinics.

If community health centers are going to continue providing services to the medically underserved persons in rural areas into the 1990's, there will have to be a major rethinking of the way that they operate. In order to recruit the doctors they need, the CHC's must offer competitive compensation packages. I feel this should include fringe benefits comparable to those offered by private group practices, such as paid malpractice and health insurance, retirement plans, and incentive programs. Some centers have, in fact, tried to adopt incentive programs for their doctors. The more patients you see, the more revenue you produce for the center, the higher your compensation will be. So far, however, the regional office of the Public Health Service has not given their permission to go ahead and establish these programs. The ultimate solution may be to allow the physicians that work for a community health center to set up an independent profession corporation which would contract with the community health center to provide the care. Whatever the form, however, the end result is the same: The community health center will need more money to provide these services.

Therefore, the community health center must develop ways of finding extra money that they need. Priority must be given to increasing collections and reducing expenses. Increased appropriations, I think, will be necessary; however, the experience of the last few years has shown that Federal money can be a very undependable source of funding. Assurances of steady funding would be very helpful in recruiting physicians, as well.

Community health centers also face a peculiar problem in generating more money from patient visits. The majority of the patients that come to our center pay $5 for their medical visit. For that $5, they get a complete office visit examination; any lab work that's necessary to be drawn; x rays, if they are indicated; and frequently a return visit to discuss results of tests that were ordered on the initial visit.

Senator PRYOR. By the way, what would that same visit cost in Boston, in one of the centers there in Boston? Where we do it for $5.

Dr. WALLER. Probably about $200, as a guess.

Senator PRYOR. Thank you.

Dr. Waller. It takes a lot of $5 office visits to produce a significant amount of increased revenue.

The health care needs of the rural population, both elderly and young, are many. A mechanism for meeting many of these needs already exists, but the community health center is in trouble due to the lack of steady and adequate funding. It would be a terrible shame to allow these facilities to disappear due to a lack of money. It will be much less expensive to keep them going now than it will be to have to reopen them later.

Thank you very much for your attention. [Applause.]

[The prepared statement of Dr. Waller follows:]

Community Health Care in Rural Arkansas

Franklin W. Waller, M.D.
Medical Director
Jefferson Comprehensive Care Center
Pine Bluff, Arkansas

Statement Before

The U.S. Senate Committee on Aging Field Hearing

Pine Bluff Convention Center
August 30, 1988

Mr. Chairman and committee members:

I appreciate the opportunity to come before you today to discuss the problems involved in delivering health care in rural Arkansas. I am a board-certified family practitioner who has been the medical director of our local community health center, Jefferson Comprehensive Care Center, for two and a half years. Dr. Kevin Fickenscher from the University of North Dakota, in previous testimony before this committee, mentioned several of the programs which were initiated during the 1970's to encourage primary care physicians to enter rural practices. I am a result of some of these programs: I attended the University of Arkansas College of Medicine which has always emphasized rural care; I joined the National Health Service Corps whose primary mission was to place physicians in rural settings; and I went through my family practice residency at the Area Health Education Center in Fayetteville, Arkansas. The AHECs were started in Arkansas and several other states to encourage young doctors to enter practice away from the metropolitan centers.

Jefferson Comprehensive Care Center operates five medical clinics, two of which are in rural areas. Our Altheimer clinic is fifteen miles northeast of Pine Bluff in a farming area. Our Redfield clinic is twenty miles north of Pine Bluff. Most of Redfield's inhabitants work at the White Bluff Generating Plant of AP&L or at the National Center For Toxicological Research. Two clinics are located here in Pine Bluff, and they will soon be consolidated into one clinic in a new building just south of the Pine Bluff Convention Center. The fifth clinic is in College Station, a small community just south of the Little Rock airport. Although College Station lies within the largest Standard Metropolitan Statistical Area (SMSA) in Arkansas, the people who live there are economically isolated from the large medical community in Little Rock and resemble the two rural populations in their needs.

What are the health care needs of these rural populations? They have many. Rural hospitals are in serious financial trouble. Last week, the Lee Memorial Hospital in Marianna closed, and the hospital in McCrory is scheduled to close this week. In our part of the state, the rural population is mostly black and poor. These people suffer from hypertension and diabetes. They have a serious problem with obesity from poor nutrition. One in five live births in Arkansas is to a teenage mother. These problems, however, can be traced to the fact that these areas suffer from the lack of access to a health care provider. One of the causes of rural hospital failure is the shortage of doctors to admit patients to them. Complications of high blood pressure and diabetes, because of poor control of the disorder, lead to heart disease, stroke, and premature death for too many people. Teenage pregnancy and perinatal complications can be related to the lack of adequate family planning counseling and prenatal care.

In spite of the efforts to encourage doctors to go to rural areas, many physicians are still clustering around the major metropolitan areas. They like the ready availability of the cultural and educational assets that a larger city has. Frequently they can associate with other doctors or large medical groups, saving the initial expense of starting a practice. Call coverage is easier in a large community, so the physician has more time off. The opportunity for a higher income is also greater in a large medical center. How can these advantages of city life be overcome?

One answer, I believe, is the community health center. By placing clinics in small rural towns, near the patients who will use them, these centers can go a long way toward providing the services these people need. Community health centers emphasize preventative care in the hope that hospitalizations can be minimized. Some centers, such as ours, can provide complete family planning, prenatal care, deliveries, and post-partum care in an effort to lower the perinatal mortality rate. CHC's can provide disease prevention services such as blood pressure screenings, cholesterol screenings, diabetes screenings, and vision screenings. They can establish education programs warning the public about the dangers of smoking, alcohol and drug abuse, obesity, and teenage pregnancy. Transportation services for those patients unable to get to the clinics on their own can be provided. This is especially important for the elderly, since many old people have difficulty driving due to disabilities or the lack of a car. Many people living in poverty in rural areas have no idea that they may be eligible for social programs or assistance. The CHC can have a social worker who can help these people cut through the red tape. The center can also help these poor people through the use of sliding fee scales, where the fee paid by the patient is dependent on the income of the patient.

That sounds like a lot, and it is. But our center provides every one of these services. The majority of CHC's can provide these. In the 1970's CHC's were started over most of the country. We have eight in Arkansas, providing care in some of the severely depressed areas of the state. In addition to our clinics, there are centers in east, southeast, and northeast Arkansas. The need for our clinics is great, and they do a great job in meeting the need.

Community health centers are standing at a crossroad right now, however. In the past, the CHC's have depended on the National Health Service Corps for the majority of their physicians. Since it takes at least seven years for a doctor to complete medical school and residency, the dramatic cuts in the NHSC funding of the early 1980's are now causing the supply of Corps doctors to dry up. This potentially can be devastating to the CHC's. A CHC has been able to pay its doctors less than they would make in private practice because the doctors were under an obligation to serve. Now that the supply of obligated doctors is small, the CHC must improve the compensation package it offers prospective physicians. Otherwise it might find itself without any doctors.

I do not mean to imply that money is the only factor. Call coverage and pre-existing facilities can be useful recruiting tools. As I mentioned before, many doctors prefer the larger cities for these reasons. However, I have been active in recruiting a new physician for our center, and I am aware of the factors a new physician is concerned about. In this area, there is about a $15,000 difference between the starting pay at our center and the first year guarantee for a family practitioner joining a private medical group. The doctor in private practice can have his or her malpractice and health insurance paid for, while many CHC physicians pay these out of their pocket, which makes their actual compensation several thousand dollars less.

This problem comes at a time when grants from the Public Health Service for CHC's are not increasing. In our region, Region VI, the total amount of money for all the CHC's in Arkansas, Oklahoma, Louisiana, Texas, and New Mexico has not increased in two years, yet the costs and expenses of the CHC's have been growing. Several centers have expanded significantly in this period, also. Increased grants to these larger centers have caused corresponding cuts to other centers. Some centers have had to cut back on services. Others have had to lay off employees.

If community health centers are going to continue providing services to the medically underserved persons in rural areas into the nineties, there will have to be a rethinking of the way they operate. In order to recruit the doctors they will need, CHC's must offer competitive compensation packages. I feel that this should include fringe benefits comparable to those offered by private group practices, such as paid malpractice and health insurance, retirement plans, and incentive programs. Some centers have tried to adopt incentive programs, but so far the regional office has not approved any of them. The ultimate solution may be to allow physicians to set up independent professional corporations which would contract with the CHC to provide services. Whatever the form, though, the end result is the same: the CHC will need more money to provide these needed services.

The CHC's must develop ways of finding the extra money they need. Priority must be given to increasing collections and reducing expenses. Increased appropriations will be necessary, but the experience of the last few years has shown that federal money can be an undependable source of funding. Assurances of steady funding would be very helpful in recruiting physicians, as well.

The health care needs of the rural population, both elderly and young, are many. A mechanism for meeting many of these needs already exists, but the community health center is in trouble due to the lack of steady and adequate funding. It would be a terrible shame to allow these facilities to disappear due to a lack of money. It will be much less expensive to keep them going now than it will be to reopen them later. Thank you for your attention.

Senator **Pryor**. Thank you very much, both of you.

All right. One question that I have. One of our witnesses today stated that we ought to look at, I don't want to say forcing, but having some the residents in the medical school at the university, that one of the requirements is that they work out in one of the areas of rural hospital and rural health care areas. Do you agree or disagree with that?

Dr. **Waller**. I think that's a good idea in principle. In fact, the Area Health Education Center here in Pine Bluff has a program similar to that. They have a satellite clinic located down in Rison, which is in Cleveland County, and their residents spend quite a bit of time—I'm not sure how much—working in the clinic there getting a feel for rural medicine, the problems and the rewards, in the hopes that some of them will be encouraged to go and find similar sorts of sites. I think this could be a beneficial thing; however, it's not cheap.

Senator **Pryor**. Dr. Nash, do you have a comment on that?

Dr. **Nash**. I know that in the—apparently, in the El Dorado AHEC near where I live, they're working on a program—I don't know all the specifics—of moving some of the residents out to the community health centers in Bearden, Hampton, and areas like that.

Senator **Pryor**. Do either of you have any final comments to make? We are very appreciative—I saw you writing some notes there just a moment ago, Dr. Nash. Dr. Waller, any final comments?

Any final comments from Judge Catlett or Ms. O'Rourke?

We want to thank all four of you. Let's give them a nice hand. Thank you very much. [Applause.]

We have one more panel this afternoon, and then we're going to open this up for comments from the floor for a short period of time, I might say.

First is certainly no stranger to any of us here and that's Betty Bradshaw, director of Southeast Arkansas Area Agency on Aging, from Pine Bluff. And then Mr. Herb Sanderson from Little Rock, director of Office on Aging and Adult Services. Herb and Betty, we appreciate both of you being here, and we look forward to your statements, and then we're going to open up for further comments from the floor. So we will call on Betty Bradshaw first.

STATEMENT OF BETTY BRADSHAW, DIRECTOR, SOUTHEAST ARKANSAS AREA AGENCY ON AGING, PINE BLUFF, AR

Ms. **Bradshaw**. Senator Pryor, I welcome and thank you for the opportunity to take part in your field hearing and to comment on the issue of rural health care.

Senator, you are to be commended for bringing health care to the forefront of issues that we are facing. Health care pertains to everyone—babies, teens, young adults, and our elderly population. Health care is crucial in enabling each of us to lead happy, productive lives.

Health care in rural areas of Arkansas is nonexistent. The State of Arkansas ranks at the bottom of the file in education, and health care in our State ranks below that. The economical impact for lack of health care is astronomical. We have seen numbers of persons who have lost a lifetime of hard work or will be paying for the rest of their earning years because of one major illness.

Arkansas ranks second in the percentage of older persons who are faced with health care problems and needs that require our attention. As a planner and provider in the field of health care for children in my earlier employment and health care for older adults at the present time, I have witnessed the lack of health care at both ends of the spectrum.

Health needs are one and the same for all. Immunization, such as the "Every Child by '74" campaign should be repeated and carry the message of all Arkansans in 1989. Preventative health care, education on nutrition, exercise, safety, abstinence from smoking, drugs, alcohol, and safe sex should be a major initiative. The next step is to have adequate, quality care available in every community within our State.

We have one major stumbling block in the provision of health care in rural areas, and that is the Arkansas Health Planning Commission which blocks expansion of health services through the certificate of need process. They base their decisions for restricting health services on inaccurate, misleading information which eliminates competition for quality, affordable health care.

We have rural hospitals in Arkansas closing often. There must be health care to take their place. This leads to home health care which has been cut 17 percent for skilled nursing care, 13 percent for physical therapy, and 24 percent for home health aid since 1981.

We need to return, possibly, to the traveling or neighborhood clinics for testing, and then make referrals if they are needed.

Give doctors a special tax break if they will go to a rural clinic 1 day a week, or allow charitable deductions, such as doctors receive when they go out of the United States to provide care; not to mandate them to do this but encourage them with special things of this nature which will encourage them to take part in it.

Use methods presently in place for welfare or SSI mothers for all mothers or fathers to go to nurse's or doctor's training. Pay their tuition, books, hospitalization, child care, and subsidy while attending school. The high divorce rate in our country mandates mothers and providers of families that need to get into a profession so they can leave the welfare rolls and become providers for their families, but they must have financial assistance and care for their children while they're furthering their education.

Shortage of physicians and nurses in rural areas. Some incentives for the nurses and doctors to go on: Encourage colleges and universities to graduate more doctors and nurses by funding their education, such as athletic scholarships. We don't expect an athlete to pay back their money to pay for their education; we give that to them. So why can't we do the same for medical professionals?

More coverage is needed for Medicare home health care. More consistency in interpretation of Medicare home regulations. Provide greater coverage for in-home services. Increase reimbursement rates for rural hospitals under the DRG system. Allow more home health aide coverage, 5 to 7 days a week as necessary. Most of our home health aides right now can provide care 2 to 3 hours a day care 3 days a week, and that will not keep our people in their homes.

The reimbursement mechanism for Medicaid and Medicare. We need a unit rate rather than a cost reimbursement which hurts both the taxpayer and the provider. Cost-based system does not provide incentive for cost saving, and no matter how high the cost, agencies do not recoup the entire amount due to the high denials. And as stated earlier, Arkansas has the highest denial rates for Medicare and Medicaid in the United States.

Cost report adjustments, et cetera. These cause hardships for private, nonprofit home health agencies, hospital-based home health agencies, and any group that is trying to provide health care. Reporting forms for Medicare and Medicaid reimbursement should follow the same patterns as private insurance. Physicians refuse to provide services to Medicaid and Medicare clients because of all the unnecessary paperwork, and then you either get slow payment or you're denied completely.

Transportation to health services is also nonexistent. We often hear, "I had to pay $10, $15, or $20 to be taken to the doctor."

Senator, we are confident, with your vast scope of expertise and perseverance, if solutions are to be found to assure quality, affordable health care for each of us, you will find them. We pledge to you our support in these endeavors and stand ready to assist you in any way possible.

Thank you. [Applause.]

Senator PRYOR. Betty, thank you very, very much. We appreciate that.

And now we're hearing from the director of the Office on Aging and Adult Services in Arkansas, Herb Sanderson.

STATEMENT OF HERB SANDERSON, DIRECTOR, OFFICE ON AGING AND ADULT SERVICES, ARKANSAS DEPARTMENT OF HUMAN SERVICES, LITTLE ROCK, AR

Mr. SANDERSON. Thank you, Senator Pryor.

First, I would like to add my congratulations to you for having this hearing. And, as Judge Catlett pointed out, you were a superb Governor and you were also a pretty good Congressman. We here in Arkansas appreciate your service.

The closing of hospitals is a concern for anybody that's providing services to the elderly. Recently, we had a meeting in Dallas, TX, that was sponsored by the Public Health Service and the Administration on Aging. It was explained that not only are rural hospitals closing but another, perhaps as serious, effect of that is that when the hospitals close, the physicians leave. So, not only do people not have access to hospitals, they do not have access to primary health care as well.

I do want to concentrate my comments on a different area than acute medical care, though. I think, while that is an important subject, we must realize that the most common problems facing elderly now are not acute problems but chronic problems. Certainly, acute care is important—when you need acute care, you need it. But the majority of elderly in Arkansas and in the United States now face chronic conditions rather than the majority of them facing acute needs. I'm not going to read my testimony, but I would like to read one excerpt out of that testimony that Robert Morris of Brandeis University stated in 1981:

> Chronic or long-term illness has generally been the stepchild of mainstream medical care, which has continued to concentrate its resources on short term, episodic medical care, leaving the more complex long-term health maintenance issues to other systems. As is often the case, the stepchild has not grown up and gone away. Instead, the unresolved dilemmas of long-term care now plague and distort all of health and medical care; acute beds are used for chronic care; timely discharge from hospitals is often difficult; nursing home care is both costly and difficult to secure for the poorest and most ill patients; and care at home has grown less rapidly than high-technology medicine. Costs of health care escalate rapidly, increased in part by these distortions.

I think we have not made much progress since 1981 in this area. Just because people have chronic problems does not mean that they should not be recognized by our health care system. In fact, our health care system should change to recognize the need for this.

We did a survey in Arkansas of over 6,000 people aged 55 and above. It was a random survey of elderly. We found over 40 percent of elders showing impairment of skills that may be crucial to their functioning independently and able to live in their own home.

You asked Dr. Elders earlier today about the number of people that did not need to be in nursing homes. Back in 1984, a study was done at that time; it was estimated that 7.6 percent of people in nursing homes had no medical reason to be there. They had a problem, but it didn't require institutionalization. But there were no options for them other than nursing homes. They could have been served by a different type of housing or an in-home service, but that didn't exist, so they were forced into an institution.

Senator PRYOR. What year was that survey?

Mr. SANDERSON. 1984.

Senator PRYOR. Thank you.

Mr. SANDERSON. By the way, it was a fairly conservative survey, as I understand it. For example, if anybody experienced incontinence at any time, one time, then they were excluded from the percent that could function outside the nursing home. So, I think it was a pretty conservative estimate.

We see today long-term care insurance policies being marketed, but these really are not long-term care insurance policies. They are really nursing home policies. As a society, we must recognize long-term care in the 1980's means more than institutional care. It means day care, home care, supervised living, in-home health care, and other such services.

One point I also would like to make is that, certainly, money is a problem for many of our elderly; however, we know that many elderly spend money unnecessarily on health care. Primarily, I'm speaking of duplicate coverage. People will purchase MediGap policies when they are on Medicaid which they do not need. And people will purchase more than one MediGap insurance policy, and that is a waste of dollars that could be redirected for hospitalization, a prescription drug program, or any other type of needed medical service. We need to do more in preventing duplicate insurance coverage.

Senator PRYOR. Herb, let me ask you a question. I'm going to make some of the insurance company people mad at me here. Are some of these companies taking advantage of a vulnerable area of our population out there trying to sell them these policies?

Mr. SANDERSON. There's no doubt about it. I'll give you an example. I knew of an incidence of a person whose husband died, and the insurance agent in this particular case followed the obituaries. And he called upon that woman a few weeks after her husband had passed away and said, "You need to buy this insurance coverage." And before he left the house, he had a check for $1,000. She already had adequate health insurance. Fortunately, she sought help and was able to get that policy canceled. I think that's pretty horrendous for somebody to look at the obituary ads and then go make a sale at that time. And, of course, we have all seen the national advertisements and, fortunately, Congress and our insurance industry has done, our insurance commission, has done something to take off the more popular people, you know, people off the TV ads. But we still see a lot of stuff in our Sunday newspapers that doesn't provide very much coverage.

Senator PRYOR. Congressman Pepper and myself, about 4 years ago, passed a piece of legislation whereby through the mails we were trying to restrict some of these, let's say, "come-ons", especially to the elderly. And that passed; it is the law. It gives the post office a lot more authority, but still now they are finding ways around this. And they're going door to door, a lot of these companies are, and there's a great vulnerability out there, I think, that we have not really solved yet.

Mr. SANDERSON. I think that's true. I talked to our insurance commissioner, our insurance commission people here, and there's basically two ways to address problems: one is through education, which we have tried; and the other is through protection. And it's their position that we need more in the area of protection. Many times when we identify somebody that has unnecessary coverage, their fear of not having adequate health care prevents them from actually canceling that coverage.

Senator PRYOR. Let me just stop here and just say one little thing.

James Roosevelt, the son of Franklin D. Roosevelt, started a group some years ago called the National Committee to Preserve Social Security and Medicare. And he writes everyone of you in this room and asks you to send in $10 every month or 2 or 3 or every year or whatever, and a lot of you write me and you say, "Senator Pryor, should I send this $10 in?" And let me answer you right now, "No, do not do it, unless you want to make him much richer than he already is."

Just put a stamp on an envelope for 25 cents and send it to us and tell us your problem, because we can do a lot more in helping you solve your problem than this organization. I think he is fleecing a lot people, myself. [Applause.] And I will probably get sued on that, so we'll just go from there.

Do you have any parting comments?

Mr. SANDERSON. Yes. Yeah, I've got a few more comments.

First of all, even where you have physician and hospital care, it doesn't do any good if somebody cannot get there. And I would like to emphasize the need for transportation. I met awhile back with a group of lawyers who were volunteering their services, and one of them told me that he was going to Newport, AR and about 10 miles outside of town saw an elderly lady hitchhiking. And he said he normally did not pick up hitchhikers, but because of her age and his curiosity, he did. And he asked her why she was doing this, and she said, "Well, I've got a physician's appointment and this is the only way I can get there." Is that an isolated story? Well, unfortunately, it may not be, because in our longitudinal study of 6,000 older Arkansans, we found that many of those experienced difficulty in obtaining transportation services to a physician's office; 39.2 percent of those individuals who had difficulty obtaining transportation were low income, and 33 percent were black elders. So, I think that's something we need to be concerned about.

And, in fact, in raising the issue of black elders, we found that black older people were in worse health and reported more difficulty in obtaining health services. So, I think that's something that needs to be looked at further.

We can only wonder how much we pay later in health care costs, how many hospitalizations could have been avoided, how much pain could have been prevented if adequate transportation had been available. But on the whole, we don't do very well in this country in the area of prevention. We pay a lot to cure or make people well after they become sick, but I don't know of any system that pays to keep people well. And that's one area that I think that we're going to have to do more in as we realize lifestyle is having a more and more important effect on our health care.

One area—one thing that I think we could do I think that would be very practical is to take the "Age Pages" that are written by the National Institute of Aging that are in large print and add them as stuffers in the Social Security checks that older people receive in this country. It would be a very simple way to provide basic health care information to people.

Another thing I would like to emphasize is what Dr. Waller said. The community health service is an excellent program. The community health centers in our State are needed. The only problem is we don't have enough of them. The model is in place; it works; it only needs more funding.

Now, Senator Pryor, I would like to close in defending my suggestion that we spend more money on some of these services. Obviously, providing more transportation and having more community health centers is going to cost more money. But I would like to say two things in closing to defend that. First, we live in an aging society, as you can see the chart over here. I mean there's just no way to avoid it, demographics are going to demand that we spend more money if we're going to provide the same level of care for our elderly people. I happen to think they deserve it. Second, I think there is a logical way to pay for some of these expanded levels of care. There have been more than 30,000 scientific articles written on the detrimental effects of smoking. A single factor, avoidance of smoking, could reduce the mortality from cancers by about one-third; chronic obstructive lung disease and peripheral vascular disease would almost be eliminated; and the mortality from aortic aneurysm would be reduced by three-fourths and that from myocardial infarction by one-fourth. As long as people smoke, we will have to treat what could have been prevented. Why not adequately tax the product that causes so much of our health care problems.

Thank you for the opportunity to appear here. [Applause.]

[The prepared statement of Mr. Sanderson follows:]

THE RURAL HEALTH CARE CHALLENGE

August 30, 1988

Pine Bluff, Arkansas

by:

Herb A. Sanderson
Arkansas Department of Human Services
Deputy Director for the
Division of Aging and Adult Services

Thank you for inviting me to share my thoughts on rural health care and the elderly.

First, Senator Pryor I thank you and congratulate you on your long and unyielding interest in older Americans. As a Congressman, Governor, and Senator your record is outstanding. We in Arkansas say thank you!

I know of no better state in which to hold a field hearing on this subject than Arkansas. Over 18% of Arkansas' population is 60 years of age or older; we have the third highest poverty rate among the elderly in the United States; and in 1980 we ranked 9th in rural population.

Today, as in previous hearings, you have heard testimony on the plight of rural hospitals. Since the elderly are the most frequent users of health care, the closing of rural hospitals is a concern of anyone associated with providing care to the elderly. Recently, the Administration on Aging and the Public Health Service hosted a meeting of aging and hospital officials. The message was not pleasant: Not only will the trend of rural hospital closings continue, but when rural hospitals close then rural physicians leave the area. If this is an accurate conclusion, many older Americans -- even when they have the ability to pay -- will find themselves without access to primary health care.

While acute medical care is of great concern, it is not the only health care need of the elderly. In fact, the most common health care problems of the elderly are chronic in nature -- not acute. This fact is too often over looked.

Some think this reality will require a rethinking of the goals of health care, Robert Morris stated it this way in 1981:

> Chronic or long-term illness has generally been the stepchild of mainstream medical care, which has continued to concentrate its resources on short-term, episodic medical care, leaving the more complex long-term health-maintenance issues to other systems. As is often the case, the stepchild has not grown up and gone away. Instead, the unresolved dilemmas of long-term care now plague and distort all of health and medical care; acute beds are used for chronic care; timely discharge from hospitals is often difficult; nursing-home care is both costly and difficult to secure for the poorest and most ill patients; and care at home has grown less rapidly than high-technology medicine. Costs of health care escalate rapidly, increased in part by these distortions.

Chronic health problems are not curable. This does not mean our health care system should ignore these problems. On the contrary, we should alter our health care delivery system to recognize that the more successful we are in conquering acute disease and postponing death, the more we aggravate the problem of long term disability.

Our office, in cooperation with the Area Agencies on Aging in our state recently published the Year One Report of the Arkansas Longitudinal Study on Health and Aging. This is a survey of over 4,000 households involving more than 6100 individuals age 55 or older.

The survey found the most common health problem among respondents to be arthritis followed by high blood pressure. Arkansas is consistent with findings from national samples. The next three most reported chronic health problems are hearing difficulty, heart condition, and eye diseases. Female elders report more health problems than male elders, black elders report more health problems than white elders, older elders report more health problems than younger elders, and lower income elders report more health problems than higher income elders. Approximately 17% of Arkansas elders over age 55 report one or more of the Activities of Daily Living (ADL) difficulties grouped into impairment of physical self care. If we include impairments which require assistance with managing cooking, light housework, shopping, laundry and other tasks which measure an individual's ability to live independently, then almost 40% of elders show some impairment of skills that may be crucial to functioning independently. As expected, all measures of impaired independence differ significantly by age. The older the age cohort, the greater the level of impairment of ability to physically care for oneself, to manage independently, and overall to live independently. These elders will require the most long term care health services.

If the rural and other elderly are to receive adequate health care, chronic conditions must be considered when revisions are proposed under Medicaid and Medicare. Private initiatives should not ignore reality either. Too many "long term care" insurance policies are not long term care policies but nursing home policies. As a society we must recognize long term care in the 80's means more than institutional care. Day care, respite care, chore services, in-home aides, transportation, and supervised living arrangements need to be added to the menu of health services available to Arkansans, rural and non-rural alike.

Where services do exist they are useless if people cannot access them. Transportation is a critical need, especially in a rural state like Arkansas. Last year I met with a group of private attorneys who volunteer to provide free legal services to low income elderly. One of the attorneys related the following story. He was on his way to Newport, Arkansas. About 10 miles outside the city he came upon an elderly lady hitchhiking. He said he normally did not pickup hitchhikers, but because of the age of the woman he made an exception. He inquired about why she was hitchhiking. She said that she had a doctors appointment and that hitchhiking was the only way she could get there.

Is this story an isolated event? Our Longitudinal Study revealed it may not be. Lack of transportation was found to be a major factor for those who had difficulty obtaining the services of a physician.

While the error rate increases for small cell sizes in our study, it is clear transportation to a doctors office is a barrier to service. For those who had difficulty in obtaining the services of a physician, 39.2% of individuals with incomes of less than $4,000 and 33.7% of black elders cited lack of transportation as the reason.

One can only wonder how much we pay later in health care costs, how many hospitalizations could have been avoided, how much pain could have been prevented, if adequate transportation had been available. But as a society we invest very little in prevention. As life-style becomes an increasingly significant factor in our health promotion and diseases prevention.

We know health care delivery in rural areas is difficult; it only seems logical to try to prevent or delay problems instead of treating them.

The "Age Page" published by the National Institute on Aging is an excellent source of basic health information available in large print. Why not routinely include these as stuffers in Social Security checks?

Another recommendation for improving rural health care is to expand the U.S. Public Health Service's Community Health Centers program. We have several of these centers in Arkansas. All have a working relationship with the Area Agency on Aging in their region. It is an excellent model of rural health care delivery. The only problem is there are not enough of the clinics. We need more of these clinics to meet the primary health care needs of rural America. The model is in place. It works. It just needs more funding.

I realize talking about expanded programs in the environment of record federal deficits may seem foolhardy. But let me conclude by saying two things in defense of putting more tax dollars into transportation, day care, in-home services, and primary health care. First, we live in an aging society. The problems we experience now in rural areas will only become greater as our population ages Demographics will dictate we pay more because we simply will have more older people. My second and final point is that there is a logical way to pay for expanded services. Over 30,000 scientific articles have been written on the detrimental effects of smoking. A single factor, avoidance of smoking, could reduce the mortality from all cancers by about one-third; chronic obstructive lung disease and peripheral vascular disease would be almost eliminated; the mortality from aortic aneurysm would be reduced by three-fourths and that from myocardial infarction by one fourth. As long as people smoke we will have to treat what could have been prevented.

Why not adequately tax the product that causes so much of our health care problems.

Thank you for allowing me the opportunity of appearing before this Senate Special Committee on Aging.

Senator PRYOR. Herb, thank you so much. And Betty, thank you very much. Thank you.

All right. First, I would like tc hear, if I might—during the break, I met a gentleman here; I believe that's Mr. Wayne Sanders. Mr. Sanders, you're from the ambulance delivery area here; I believe that would be correct. And if you would like to just come up to this microphone and stand and give your name and where you're from so that the record will reflect this.

STATEMENT OF WAYNE SANDERS, OWNER OF HEMPSTEAD COUNTY AMBULANCE SERVICE, INC., HOPE, AR

Mr. SANDERS. Yes, sir. Senator Pryor, I own the ambulance service in Hope, AR. And we are faced every day with the same problems that the rural hospitals are. It's the denial by Medicare and Medicaid that we have for our services offered. For instance, we're still operating on a prevailing rate that was established back in 1983 right now. Medicare and Medicaid will not pay for services of carrying the elderly to a doctor's office for preventive maintenance, or whatever you want to call it, for the, you know, patient to receive the medical treatment before entering a hospital. They will not pay us for carrying a patient from a home or from a nursing home to a home or whatever, and a lot of times this is the only way that these people have to travel.

Like on Medicare, we were receiving $52.89 as our reimbursement from Medicare. Like on O^2, our oxygen charges, and then like if we have an accident and someone is involved in an accident, they deny a lot of our charges that we have to have. But our costs still keep going, like our ambulances and stuff, they rise in costs every day. The personnel are trained to go advance life support, which I believe everyone in the State of Arkansas and every State deserves advance life support services instead of just the basic life support.

If you give basic life support in these rural areas, you're 15 to 20 minutes from a hospital. If you have someone that's in cardiac arrest, the hospitals are fighting a losing battle when you get them to their facility because of the time period that is involved. It's a proven fact that CPR without advance life support is not as effective. Well, if not, by the time, like I said, by the time you get to this facility, these people have already got way behind in the ball game. You're playing "catch up ball," and with people's lives, you don't want to play "catch up ball." And that's why I would like to see Medicare and Medicaid come up on their prevailing rates like the surrounding States—Texas, Oklahoma. They're all above what we are right now. And we would like to see, you know, for doctor's office calls for these elderly people, because like I said, we've carried people back and forth to the hospital for physical therapy from our nursing homes that are bed confined. Then we're denied the charges because these services they state were not needed. Well, a doctor felt it was needed. They call us because this is the only way these people have to travel. Then we lose the whole call, because we don't get repaid for the call. We have got to maintain a service 24 hours a day, 7 days a week. We've got to be ready to go with at least two ambulances in our area because you never know when there's more than one person at a time going to get sick. There's no set record.

Senator **Pryor**. Let me ask this, if you don't mind revealing this for the public.

Mr. **Sanders**. Yes, sir.

Senator **Pryor**. If you do, you can tell me in private. What would be the cost of your malpractice insurance?

Mr. **Sanders**. Right now, the cost for an EMC, which is a basic EMTA, it's lower than what a doctor's is, a lot lower. Right now, I can buy malpractice for our service for roughly $500 a year, plus it's $200 per employee per year. And that's not giving but like a $500,000 malpractice insurance per employee. And we're in the process right now of buying this insurance for our employees. Hope is approximately 10,000 population, give a few or less, and I employ 20 people in our service at this time, part time and full time. Like I said, we run the service 24 hours a day, keep it staffed for two ambulances to be ready to respond to a call at any given time during the day or night.

Senator **Pryor**. I want to thank you very much, Wayne. We appreciate that contribution.

Mr. **Sanders**. Thank you, sir. [Applause.]

[The prepared statement of Mr. Sanders follows:]

HEMPSTEAD COUNTY AMBULANCE SERVICE, INC.
508 EAST THIRD
P. O. BOX 1171
HOPE, ARKANSAS 71801
FD. ID# 71-0413702

Wayne Sanders

Senator Pryor:

We, like many other ambulance services in Arkansas, are being forced to remain at a basic level of care or go completely out of business because of the reimbursement from Medicare and Medicaid. For instance, Medicare and Medicaid are still paying Arkansas based ambulance services the same prevailing rate as in 1983. As you well know, the prices of help, equipment, ambulances and every day expenses to operate on have not been frozen since 1983.

Our average distance traveled on each call will be approximately 6 to 7 miles. We cover all of Hempstead County and part of Nevada County and the majority of these people are on Medicare or Medicaid. With the increase of home health care, there are many of these people that have to be transported to doctors offices for regular check ups. These calls are not covered by Medicare or Medicaid.

Being in our situation, when a call comes in we have to respond to the call. Maybe, if we are lucky, Medicare or Medicaid will pay a portion of the call. In most instances, the people on Medicare or Medicaid cannot pay the remainder of the bill so we have to absorb it.

Another point to be brought out is that some of the time Medicare and Medicaid do not see it necessary for travel by an ambulance. We cannot make that decision at the time of the call. We have had several of these calls from our local nursing homes for a patient to be transported to Medical Park Hospital to receive physical therapy. It may take several trips to complete the therapy ordered by a physician but when filed with Medicare or Medicaid for payment it may be turned down because they say it was not necessary for an ambulance even if this patient is bed confined.

Another critical charge that is not paid on is C.P.R. There is one thing definate. If C.P.R. was not done the people would surely not make it.

Medicare and Medicaid do not pay for splinting a fractured arm or leg because they say the equipment is all ready on board the unit. This equipment does eventually wear out. They will not pay for spinal immobilization and this, like C.P.R., could lead to perminate death if not performed. There is more involved than just the equipment. The personel working on ambulances have to have a certain amount of continuing education and this also costs a great deal of money.

The main point to be brought out is that Arkansas needs to pay comparable amounts in Medicare and Medicaid as the surrounding states do or we as ambulance services cannot give Advance Life Support Services. Without this, the hospital emergency rooms are fighting a losing battle trying to provide this for the people of Arkansas. Let's just hope it's not my family or yours that needs Advance Life Support in the field.

Sincerely,

Wayne Sanders, Owner
Hempstead County Ambulance Service, Inc.

this was 1985 price

ESTIMATED INVESTMENT REQUIREMENTS

	Ambulance Service
1 ambulances at $25,000 each	$25,000
On-board medical & extrication equipment	2,900
Base station with paging capabilities	6,000
2 radio pagers at $500 each	1,000
1 mobile unit at $3,500 each	3,500
TOTAL	$38,400

OPERATING EXPENSES

Item	Costs and Usage
Gasoline	10 miles per gallon at $1.00 per gallon
Tires	Replaced every 15,000 miles at $80 per tire
Motor Oil	Changed every 1,500 miles at $1.00 per quart - 5qts./vehicle
Oil Filter	Replaced each oil change at $5.00 each
Lubrication	Done every 2,000 miles at $4.50 each
Tune-up	Every 10,000 miles at $45 per tune-up
Miscellaneous Repairs	$3000 per vehicle per year
Communication System Maintenance	$300 per service per year
Linen Expense	75 cents per call
Medical Equipment Maintenance	$2.00 per call
Sterile Bandages & Related Items	$1.65 per call
Labor	For a full time ambulance service, labor was estimated at the rate of $7,500 per EMT for 6 EMT's + 12% for fringe benefits; 1 clerical person at $12,500
Rent	$9000 per service for full-time ambulance service
Malpractice Insurance	$300 per vehicle per year
Utilities	$4700 per service per year for full-time ambulance service
Telephone	$2500 per service for full-time ambulance services

OPERATING REVENUE

The cost of an ambulance call to the patient was assumed to be $80 per call plus $2 per loaded mile. Loaded miles are the miles of an ambulance call that the patient is being transported. Loaded miles were assumed to be one-half of the total miles traveled. It was assumed that the average distance traveled per call was 20 miles.

Estimated Revenue Per Call

Charge per call	$80
Mileage charge per call	$20
TOTAL	$100 potential revenue per call

Estimated Costs Per Call*

Number of Runs Per Year	Full-time Ambulance Service
200 runs	$437.09
400 runs	$222.10
600 runs	$150.43
800 runs	$114.59

*Estimated Costs per call does not include depreciation on vehicles and communication equipment. Neither does it include interest expense or bad debt expense.

ESTIMATED REVENUE vs. EXPENSE BASED ON RUNS MADE

Runs Annually:	200	400	600	800
Revenue:				
Fee @ $80 per call	16,000	32,000	48,000	64,000
Mileage @ $2 (10 loaded mi. per call)	4,000	8,000	12,000	16,000
	20,000	40,000	60,000	80,000
50% Collection	10,000	20,000	30,000	40,000
Costs:				
Rent	9,000	9,000	9,000	9,000
Labor	57,500	57,500	57,500	57,500
Fringe Benefits	6,900	6,900	6,900	6,900
Utilities	4,700	4,700	4,700	4,700
Telephone	2,500	2,500	2,500	2,500
Malpractice Ins.	300	300	300	300
Vehicle Ins.	1,800	1,800	1,800	1,800
Gasoline	400	800	1,200	1,600
Tires	85	170	255	340
Motor Oil	13	27	40	53
Oil Filter	13	27	40	53
Lubrication	9	18	27	36
Tune Ups	18	36	54	72
Miscellaneous Repair	3,000	3,000	3,000	3,000
Communication System Repair	300	300	300	300
Linen Expense	150	300	450	600
Medical Equip. Maint.	400	800	1,200	1,600
Sterile Bandages & Supplies	300	660	990	1,320
TOTAL:	$87,418	$88,838	$90,256	$91,674

HEMPSTEAD COUNTY AMBULANCE SERVICE, INC.
HIGHWAY 67 EAST OF HOPE
P. O. BOX 6616
PERRYTOWN, ARKANSAS 71801
801-777-3334

June 6, 1984

Mrs. Vonni Gundolf, Supervisor
Utilization Review Division
Medicare Services
P. O. Box 1418
Little Rock, Arkansas 72203

Dear Mrs. Gundolf,

I am writing to you concerning the rates that we are charging our patients for ambulance service here in Hempstead County, and the possibility of obtaining your permission to increase our rates to help defray the increasing cost of our operation.

We have operated the ambulance service for Hope and Hempstead County now for fifteen years and the city and county have just renewed our exclusive contract agreement for the next three years, but without an increase in our subsidy from them.

This letter is to respectfully request your consideration to allow us a gross inequity increase in our rates.

We have operated at a loss for the past several years due to inflation in general, and particularly in the expenses related to oil, gasoline, repairs, as well as substantial increases of all of our other expenses such as salaries, utilities, insurance, taxes, and other expenses related to the operation of a first-class ambulance service. We expect inflation in general to continue and we expect continued increases in our cost of oil, gasoline, and other expenses related to our operation even at a greater rate than ever.

We, of course, cannot continue to operate our ambulance service at a loss, and we have tried to cut our expenses in operation in every way that we possibly could, but we expect that we still will operate at a loss unless we increase our rates.

We have just purchased two new ambulance, fully equipped, to replace the two that we are using now, as they are completely worn out, and we cannot operate without this equipment.

We have, according to the terms and conditions of our contract with Hope and Hempstead County, Arkansas, formally requested their permission to increase our rates, and both bodies of goverment have granted this request.

HEMPSTEAD COUNTY AMBULANCE SERVICE, INC.
HIGHWAY 67 EAST OF HOPE
P. O. BOX 6616
PERRYTOWN, ARKANSAS 71801
501-777-3334

Mrs. Vonnie Gundolf, Supervisor
Page: 2

The new rates, effective immediately, are $85.00 for a Basic Local Emergency pickup. The old rate was $65.00. A Basic Local-Non-Emergency pickup will be $75.00. The old rate was $55.00. The new Mileage Rate will be $2.00 per mile one-way. The old rate was $1.75 per mile one-way. The new Oxygen charge will be $20.00. The old Oxygen charge was $15.00. The new First Aid (Nonreusable Supplies) charge will be $20.00. The old First Aid charges was $15.00.

We arrived at the above new rates by calling other ambulance services in our area, including Nevada County, Columbia County, and Howard County, and their rates are the same or higher.

Many of our patients are covered by Medicare, Medipak, and Medicaid, and our new rates would not apply to them unless you would see fit to allow us a gross inequity increase in our rates approved by you.

We would appreciate your allowing us a gross inequity increase, effective as soon as possible, to the above outlined rates.

I would be happy to meet with you or anyone else in your office at any time if any additional information is desired.

We would appreciate, very much, your favorable approval of this gross inequity increase in our rates, and we are thanking you in advance for your help and cooperation in this matter.

Sincerely yours,

Larry Moses, Secretary-Treasurer
HEMPSTEAD COUNTY AMBULANCE SERVICE, INC.

(Provider's Code No. 47159)

MEDICARE SERVICES
P.O. BOX 1418 • LITTLE ROCK, ARKANSAS 72203-1418
TITLE XVIII-PUBLIC LAW 89-97

May 20, 1988

47159 59
HEMPSTEAD CO AMB SERV
508 EAST 3RD
P O BOX 1171
HOPE, AR. 71801

Dear Sirs:

We are reviewing the Medicare prevailing rate for procedure code A0010, ambulance service, basic life support (BLS) base rate, emergency transport, one way. This is being done under the inherent reasonableness provision of the Medicare law because this rate is so much lower than other Carriers in the Dallas region.

In order to help you understand the calculation of the current rates, I would like to explain some changes which have taken place in recent years with regards to ambulance service reimbursement.

1. Ambulance services billed during January 1, 1983 through December 31, 1983 were used to develop customary and prevailing fees for 1985.
2. Customary and prevailing fees developed for 1985 were used to pay claims with dates of service July 1, 1984 through December 31, 1986.
3. The Inflation Indexed Charge limitation, implemented effective 1/1/87 to limit non-physician services was applied to the 1985 customary and prevailing fees. A 1.7% increase was applied to the 1985 customary and prevailing fees to be used when paying claims with dates of service January 1, 1987 and after.
4. Non-physician fees (Ambulance, Durable Medical Equipment, etc.) were not updated 1/1/88 but were frozen at the 87 level. Therefore, the amount used to pay claims for services January 1, 1987 through December 31, 1987 would also apply to services with dates of service January 1, 1988 through December 31, 1988.

In order to facilitate this review, it is important that all ambulance providers in the state complete this form so the results will be considered complete and valid. We need your cooperation in completing the attached questionaire and returning it to my attention in the enclosed postage paid envelope no later than June 13, 1988.

Thank you in advance for your time.

Sincerely,

(Mrs.) Vonni Gundolf
Supervisor, Reasonable Charge
Utilization Review Division

VG:sw

Total ~~Chg~~ Chgs. for this Page $630.00

Total Pay for this Page $332.62

NAME OF PATIENT	HEALTH INSURANCE CLAIM NUMBER / CLAIM CONTROL NUMBER	PHYSICIAN OR SUPPLIER	FROM MO.	FROM DAY	TO MO.	TO DAY	R	PROCED CODE	NO. SRV	SRV TYPE	SRV PLACE	TOTAL CHARGES	NON-ALLOWED CHARGES						EXPLANATION OF ANY NON-ALLOWED CHARGES OR OTHER PAYMENT DEDUCTIONS
C MCFADDEN	432269763A	47159	07	31	07	31	8	A0010	01	I	7	85.00	18.89						REDUCTION - SEE NOTE C ON BACK
081688/081688	822212827-00	CLAIMS TOTAL										85.00	18.89	0.00	13.22	0.00	0.00	52.89	
													PAYMENT INFORMATION HAS BEEN FORWARDED TO THE SUPPLEMENTAL INSUROR NOTED ON YOUR CLAIM.						
L MORRIS	429227297D	47159	07	29	07	29	8	A0010	01	I	7	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
080888/081588	821613885-00	CLAIMS TOTAL										85.00	18.89	0.00	13.22	0.00	0.00	52.89	
A		47159	08	01	08	01	8	A0010	01	I	7	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
	-00	CLAIMS TOTAL										85.00	18.89	0.00	13.22	0.00	0.00	52.89	
													PAYMENT INFORMATION HAS BEEN FORWARDED TO THE SUPPLEMENTAL INSUROR NOTED ON YOUR CLAIM.						
A		47159	06	28	06	28	8	A0010	01	I	7	85.00	85.00						UNABLE TO OBTAIN INFO REQ'D - SEE REMARKS
	-00	CLAIMS TOTAL										85.00	85.00	0.00	0.00	0.00	0.00	0.00	
													PAYMENT INFORMATION HAS BEEN FORWARDED TO THE SUPPLEMENTAL INSUROR NOTED ON YOUR CLAIM. ALL OR PART OF THIS CLAIM WAS DENIED BECAUSE OF INSUFFICIENT INFORMATION. NO REPLY TO OUR REQUEST FOR ADDITIONAL CLAIM DATA HAS BEEN RECEIVED. A CLAIM FOR THE DENIED SERVICES MAY BE RESUBMITTED WITH THE ADDITIONAL INFORMATION.						
B		47159	03	22	03	22	8	A0070	01	I	7	30.00	14.74						R/C REDUCTION - SEE NOTE C ON BACK
		47159	03	22	03	22	8	A0999	01	I	7	20.00	0.00						
		47159	03	22	03	22	8	A0020	35	I	7	70.00	16.45						R/C REDUCTION - SEE NOTE C ON BACK
		47159	03	22	03	22	8	A0010	01	I	7	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
	-00	CLAIMS TOTAL										205.00	50.08	0.00	30.99	0.00	0.00	121.06	GR-REDUCTION 2.87
P WILLIAMS	466120275D	47159	07	29	07	29	8	A0010	01	I	7	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
081188/081388	822119407-00	CLAIMS TOTAL										85.00	18.89	0.00	13.22	0.00	0.00	52.89	
													PAYMENT INFORMATION HAS BEEN FORWARDED TO THE SUPPLEMENTAL INSUROR NOTED ON YOUR CLAIM.						

Total Pay for These 6 Pages $1802.76

Total Chg. for These 6 Pages $3,806.00

for a Diff. of $2,003.24

This is lost.

Geigy

BRETHAIRE® terbutaline sulfate inhaler

L

Total Charge for This Page. $760.00

Total Pay for This Page $446.03

NAME OF				OTAL ARGES	NON-ALLOWED CHARGES	DEDUCTIBLE	CO-INSURANCE	WITHHELD FOR OFFSET OR AMOUNT PREVIOUSLY PAID	MEDICARE PAYMENT TO PATIENT	MEDICARE PAYMENT TO PHYSICIAN OR SUPPLIER	EXPLANATION OF ANY NON-ALLOWED CHARGES OR OTHER PAYMENT DEDUCTIONS
S BOSWE				30.00	14.74						R/C REDUCTION - SEE NOTE C ON BACK
		47159	05260526BA001001 17	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
062488/062588	817414140-00	CLAIMS TOTAL		115.00	33.63	0.00	16.27	0.00	0.00	65.10	
				PAYMENT INFORMATION HAS BEEN FORWARDED TO THE SUPPLEMENTAL INSUROR NOTED ON YOUR CLAIM.							
C BYRD	432162401A	47159	05220522BA001001 17	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
62188/062188	816916179-00	CLAIMS TOTAL		85.00	18.89	0.00	13.22	0.00	0.00	52.89	
EUBANKS	430223077M	47159	05230523BA001001 17	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
062388/062368	817313751-00	CLAIMS TOTAL		85.00	18.89	0.00	13.22	0.00	0.00	52.89	
				PAYMENT INFORMATION HAS BEEN FORWARDED TO THE SUPPLEMENTAL INSUROR NOTED ON YOUR CLAIM.							
E GARANFLO	344189918A	47159	05180518BA001001 17	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
		47159	05180518BA099901 17	20.00	20.00						NONCOVERED SERVICES
062188/062188	816916180-00	CLAIMS TOTAL		105.00	38.89	0.00	13.22	0.00	0.00	52.89	
E GARANFLO	344189918A	47159	05240524BA001001 17	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
062388/062388	817313748-00	CLAIMS TOTAL		85.00	18.89	0.00	13.22	0.00	0.00	52.89	
D JONES	429121454A	47159	02260226BA001001 17	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
		47159	02260226BA007001 17	30.00	14.74						R/C REDUCTION - SEE NOTE C ON BACK
052788/062588	814444328-00	CLAIMS TOTAL		115.00	33.63	0.00	16.28	0.00	0.00	63.59	GR-REDUCTION 1.50
M PATRICK	431221588D	47159	05230523BA001001 17	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
062388/062388	817313750-00	CLAIMS TOTAL		85.00	18.89	0.00	13.22	0.00	0.00	52.89	
V PUTMAN	432528787D	47159	05310531BA001001 17	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
062488/062588	817414139-00	CLAIMS TOTAL		85.00	18.89	0.00	13.22	0.00	0.00	52.89	
				PAYMENT INFORMATION HAS BEEN FORWARDED TO THE SUPPLEMENTAL INSUROR NOTED ON YOUR CLAIM.							

NAME OF PATIENT	HEALTH INSURANCE CLAIM NUMBER / CLAIM CONTROL NUMBER	PHYSICIAN OR SUPPLIER	DATE(S) OF SERVICE FROM MO.	FROM DAY	TO MO.	TO DAY	YR.	PROCEDURE CODE	NO SRV	SRV TYPE	SRV PLACE	TOTAL CHARGES	NON-ALLOWED CHARGES	DEDUCTIBLE	CO-INSURANCE	WITHHELD FOR OFFSET OR AMOUNT PREVIOUSLY PAID	MEDICARE PAYMENT TO PATIENT	MEDICARE PAYMENT TO PHYSICIAN OR SUPPLIER	EXPLANATION OF ANY NON-ALLOWED CHARGES OR OTHER PAYMENT DEDUCTIONS
		47159	02	11	02	11	8	A0010	01	1	7	85.00	18.89						NOTE C ON BACK R/C REDUCTION - SEE
		47159	02	11	02	11	8	A0070	01	1	7	30.00	14.74						NOTE C ON BACK R/C REDUCTION - SEE
052488/052688	814015021-00	CLAIMS TOTAL										200.00	52.52	0.00	29.50	0.00	0.00	115.25	NOTE C ON BACK GR-REDUCTION 2.73
A HOUSER	429503557D4	47159	01	20	01	20	8	A0010	01	1	7	85.00	85.00						SERVICES FOR THE REPORTED CONDITION
		47159	01	20	01	20	8	A0060	06	1	7	40.00	40.00						SERVICES FOR THE REPORTED CONDITION
052488/052688	814015024-00	CLAIMS TOTAL										125.00	125.00	0.00	0.00	0.00	0.00	0.00	GR-REDUCTION 0.00
C WHITE	446050120A	47159	03	01	03	01	8	A0010	01	1	7	85.00	85.00						**SEE REMARKS**
040888/052688	809614528-00	CLAIMS TOTAL										85.00	85.00	0.00	0.00	0.00	0.00	0.00	GR-REDUCTION 0.00

THIS CLAIM WAS NOT CONSIDERED FOR PAYMENT SINCE WE HAVE NOT BEEN ABLE TO VERIFY THAT MEDICARE IS THE PRIMARY INSURER FOR FOR THE SERVICES RENDERED. ALTHOUGH WE HAVE WRITTEN THE BENIFICIAR REQUESTING ADDITIONAL INFORMATION REGARDING GROUP COVERAGE, NO RESPONSE HAS BEEN RECEIVED. WE ARE, THEREFORE, UNABLE TO TAKE FURTHER ACTION ON THIS CLAIM.

NAME OF PATIENT	HEALTH INSURANCE CLAIM NUMBER / CLAIM CONTROL NUMBER	PHYSICIAN OR SUPPLIER	DATE(S) OF SERVICE FROM MO.	FROM DAY	TO MO.	TO DAY	YR.	PROCEDURE CODE	NO SRV	SRV TYPE	SRV PLACE	TOTAL CHARGES	NON-ALLOWED CHARGES	DEDUCTIBLE	CO-INSURANCE	WITHHELD FOR OFFSET OR AMOUNT PREVIOUSLY PAID	MEDICARE PAYMENT TO PATIENT	MEDICARE PAYMENT TO PHYSICIAN OR SUPPLIER	EXPLANATION OF ANY NON-ALLOWED CHARGES OR OTHER PAYMENT DEDUCTIONS
L WHITLOW	430055127D	47159	04	25	04	25	8	A0010	01	1	7	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
051788/052488	813314342-00	CLAIMS TOTAL										85.00	18.89	0.00	13.22	0.00	0.00	52.89	

THE CLAIM NUMBER SHOWN ON THIS CLAIM WAS INCORRECT OR MISSING. ON FUTURE CLAIMS FOR THIS BENEFICIARY, PLEASE USE THE NUMBERS AND LETTERS EXACTLY AS INDICATED HERE. THIS WILL ENABLE US TO PROCESS YOUR FUTURE CLAIMS PROMPTLY.

Total
Chg. for
This Page
$495.00

Total Paid
for This Page
$168.14

NAME OF PATIENT	HEALTH INSURANCE CLAIM NUMBER / CLAIM CONTROL NUMBER	PHYSICIAN OR SUPPLIER	DATE(S) OF SERVICE FROM MO	DAY	TO MO	DAY	YR	PROCEDURE CODE	NO. SRV	SRV TYPE	SRV PLACE	TOTAL CHARGES	NON-ALLOWED CHARGES	DEDUCTIBLE	CO-INSURANCE	WITHHELD FOR OFFSET OR AMOUNT PREVIOUSLY PAID	MEDICARE PAYMENT TO PATIENT	MEDICARE PAYMENT TO PHYSICIAN OR SUPPLIER	EXPLANATION OF ANY NON-ALLOWED CHARGES OR OTHER PAYMENT DEDUCTIONS
F ARMSTRONG	453107395D	47159	04	08	04	08	8	A0010	01	1	7	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
052088/052088	813813102-00	CLAIMS TOTAL										85.00	18.89	0.00	13.22	0.00	0.00	52.89	
C BETTS	429054033A	47159	04	25	04	25	8	AC010	01	1	7	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
051788/051788	813314344-00	CLAIMS TOTAL										85.00	18.89	0.00	13.22	0.00	0.00	52.89	
													PAYMENT INFORMATICN HAS BEEN FORWARDED TO THE SUPPLEMENTAL INSUROR NOTED ON YOUR CLAIM.						SUPPLEMENTAL
A BROWN	432128101B	47159	01	08	01	08	8	AC070	01	1	7	30.00	14.74						R/C REDUCTION - SEE NOTE C ON BACK
		47159	01	08	01	08	8	AC010	01	1	7	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
052088/052088	813813107-00	CLAIMS TOTAL										115.00	33.63	0.00	16.28	0.00	0.00	63.59	GR-REDUCTION 1.50
J BRYSON	530071086A	47159	04	12	04	12	8	AC010	01	1	7	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
050788/051988	812614003-00	CLAIMS TOTAL										85.00	18.89	0.00	13.22	0.00	0.00	52.89	
M GENTRY	432581586A	47159	04	08	04	08	8	AC010	01	1	7	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
051888/051888	813414008-00	CLAIMS TOTAL										85.00	18.89	0.00	13.22	0.00	0.00	52.89	
M JONES	429503146A	47159	01	21	01	21	8	AC010	01	1	7	85.00	85.00						DUP CLAIM, 8048155020
052088/052088	813813106-00	CLAIMS TOTAL										85.00	85.00	0.00	0.00	0.00	0.00	0.00	GR-REDUCTION 0.00
P PERKINS	431090951D	47159	01	08	01	08	8	A0010	01	1	7	85.00	85.00						AMBULANCE TO AND FROM DR'S OFFICE
051888/051888	813414010-00	CLAIMS TOTAL										85.00	85.00	0.00	0.00	0.00	0.00	0.00	GR-REDUCTION 0.00
E VOLENTINE	429037699D	47159	02	05	02	05	8	AC010	01	1	7	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
		47159	02	05	02	05	8	A0999	01	1	7	40.00	40.00						NONCOVERED SERVICES
		47159	02	05	02	05	8	A0999	01	1	7	100.00	100.00						NONCOVERED SERVICES
		47159	02	05	02	05	8	A0070	01	1	7	30.00	14.74						R/C REDUCTION - SEE NOTE C ON BACK
052088/052088	813813103-00	CLAIMS TOTAL										255.00	173.63	0.00	16.28	0.00	0.00	63.59	GR-REDUCTION 1.50
													PAYMENT INFORMATICN HAS BEEN FORWARDED TO THE SUPPLEMENTAL INSUROR NOTED ON YOUR CLAIM.						SUPPLEMENTAL
												880.00		0.00		0.00			

won't pay

Total CHg for This Page $880.00

Total Paid for This Page $338.74

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NAME OF PATIENT	HEALTH INSURANCE CLAIM NUMBER / CLAIM CONTROL NUMBER	PHYSICIAN OR SUPPLIER	DATE(S) OF SERVICE FROM		DATE(S) OF SERVICE TO			PROCEDURE CODE	NO. SRV	SRV TYPE	SRV PLACE	TOTAL CHARGES	NON-ALLOWED CHARGES	DEDUCTIBLE	CO-INSURANCE	WITHHELD FOR OFFSET OR AMOUNT PREVIOUSLY PAID	MEDICARE PAYMENT TO PATIENT	MEDICARE PAYMENT TO PHYSICIAN OR SUPPLIER	EXPLANATION OF ANY NON-ALLOWED CHARGES OR OTHER PAYMENT DEDUCTIONS
			MO	DAY	MO	DAY	YR												
R DELANEY	429360583D	47159	04	04	04	04	8	A0010	01	1	7	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
050588/051488	812413607-00	CLAIMS TOTAL										85.00	18.89	0.00	13.22	0.00	0.00	52.89	
													PAYMENT INFORMATION HAS BEEN FORWARDED TO THE SUPPLEMENTAL INSUROR NOTED ON YOUR CLAIM.						
H FORMBY	514091483D	47159	04	16	04	16	8	A0010	01	1	7	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
		47159	04	16	04	16	8	A0060	01	1	7	40.00	40.00						NONCOVERED SERVICES
050788/051488	812614005-00	CLAIMS TOTAL										125.00	58.89	0.00	13.22	0.00	0.00	52.89	
T JOPLIN	429103239A	47159	04	17	04	17	8	A0070	01	1	7	30.00	14.74						R/C REDUCTION - SEE NOTE C ON BACK
		47159	04	17	04	17	8	A0010	01	1	7	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
051088/051488	812715200-00	CLAIMS TOTAL										115.00	33.63	5.20	15.23	0.00	0.00	60.94	
L MCBAY	429360105A	47159	04	17	04	17	8	A0010	01	1	7	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
051288/051288	813113412-00	CLAIMS TOTAL										85.00	18.89	0.00	13.22	0.00	0.00	52.89	
TOTALS												410.00	130.30	5.20	54.89	0.00	0.00	219.61	GR-REDUCT 0.00 OTHR PD AMT 0.00 INTEREST 0.00

BRETHAIRE®
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Geigy

623-5418-A

Total chg for
This Page
$410.00

Total Pay
for This Page
$219.61

Total Chg. for This Page $631.00

Total Pay for This Page $297.62

NAME OF PATIENT	HEALTH INSURANCE CLAIM NUMBER / CLAIM CONTROL NUMBER	PHYSICIAN OR SUPPLIER	DATE(S) OF SERVICE FROM MO.	DAY	TO MO	DAY	YR	PROCEDURE CODE	NO SRV	SRV TYPE	SRV PLACE	TOTAL CHARGES	NON-ALLOWED CHARGES	DE					EXPLANATION OF ANY NON-ALLOWED CHARGES OR OTHER PAYMENT DEDUCTIONS
P ALLEN	429369956D	47159	08	01	08	01	8	A0010	01	I	7	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
		47159	08	01	08	01	8	A0020	03	I	7	6.00	1.41						R/C REDUCTION - SEE NOTE C ON BACK
081688/081688	822212828-00	CLAIMS TOTAL										91.00	20.30	0.00	14.14	0.00	0.00	56.56	
													THE CLAIM NUMBER SHOWN ON THIS CLAIM WAS INCORRECT OR MISSING. ON FUTURE CLAIMS FOR THIS BENEFICIARY, PLEASE USE THE NUMBERS AND LETTERS EXACTLY AS INDICATED HERE. THIS WILL ENABLE US TO PROCESS YOUR FUTURE CLAIMS PROMPTLY. PAYMENT INFORMATION HAS BEEN FORWARDED TO THE SUPPLEMENTAL INSUROR NOTED ON YOUR CLAIM.						
R FIELD	429828946M	47159	07	29	07	29	8	A0010	01	I	7	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
		47159	07	29	07	29	8	A0010	01	I	7	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
080888/081688	821613883-00	CLAIMS TOTAL										170.00	37.78	50.00	16.44	0.00	0.00	65.78	
													PAYMENT INFORMATION HAS BEEN FORWARDED TO THE SUPPLEMENTAL INSUROR NOTED ON YOUR CLAIM.						
H FORMBY	514091483D	47159	08	03	08	03	8	A0010	01	I	7	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
081688/081688	822212825-00	CLAIMS TOTAL										85.00	18.89	0.00	13.22	0.00	0.00	52.89	
E GARANFLO	344189918A	47159	07	26	07	26	8	A0010	01	I	7	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
080888/081588	821613887-00	CLAIMS TOTAL										85.00	18.89	0.00	13.22	0.00	0.00	52.89	
													PAYMENT INFORMATION HAS BEEN FORWARDED TO THE SUPPLEMENTAL INSUROR NOTED ON YOUR CLAIM.						
T HARRELL	429010396B	47159	08	01	08	01	8	A0010	01	I	7	85.00	18.89						R/C REDUCTION - SEE NOTE C ON BACK
081688/082088	822212829-00	CLAIMS TOTAL										85.00	18.89	1.65	12.89	0.00	0.00	51.57	
													PAYMENT INFORMATION HAS BEEN FORWARDED TO THE SUPPLEMENTAL INSUROR NOTED ON YOUR CLAIM.						
J LEE	430206677A	47159	03	24	03	24	8	A0020	15	I	7	30.00	7.05						R/C REDUCTION - SEE NOTE C ON BACK
		47159	03	24	03	24	8	A0010	01	I	7	85.00	85.00						DUP CLAIM, 8158181330 07/29/88
080888/081688	821613892-00	CLAIMS TOTAL										115.00	92.05	0.00	4.59	0.00	0.00	17.93	GR-REDUCTION 0.43
													PAYMENT INFORMATION HAS BEEN FORWARDED TO THE SUPPLEMENTAL INSUROR NOTED ON YOUR CLAIM.						
TOTALS																			

Hempstead County Ambulance Ser. Hope, Ar. Wayne

STATE OF ARKANSAS

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

HEMPSTEAD COUNTY AMBULANCE SERV
PO BOX 1171
HOPE AR 71801

R/A NUMBER 587401

PROVIDER NUMBER 102599715 REPORT SEQ. NUMBER 24 DATE 07/07/88 PAGE 6

NAME / RECIPIENT ID | SERVICE DATES FROM MM DD YY TO MM DD YY | DAYS OR UNITS | PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION | TOTAL BILLED | NON ALLOWED | TOTAL ALLOWED | SPENDDOWN | PATIENT LIABILITY | OTHER DEDUCTED CHARGES | PAID AMOUNT | EOB CODES

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   CLAIMS IN PROCESS - THESE CLAIMS ARE BEING PROCESSED AS LISTED
   PROFESSIONAL
0966561101  FURR        DEBRA L 022388 022388 ICN 9888155062070    95.00  MEDICAL RECORD = 0          14
0605913001  STUEART     ALLIE M 012788 012788 ICN 9888162061900    85.00  MEDICAL RECORD = 0         116
0605913001  STUEART     ALLIE M 012388 012388 ICN 9888162061940   115.00  MEDICAL RECORD = 0         116
0605913001  STUEART     ALLIE M 012388 012388 ICN 9888162061950    85.00  MEDICAL RECORD = 0         116
0605913001  STUEART     ALLIE M 012788 012788 ICN 9888162061930    85.00  MEDICAL RECORD = 0         116

     5      CLAIMS                  PROFESSIONAL        *******   46500

****-->     TOTAL PENDING CLAIMS              5 CLAIMS            465.00
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STATE OF ARKANSAS

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

HEMPSTEAD COUNTY AMBULANCE SERV
PO BOX 1171
HOPE AR 71801

R/A NUMBER 591651

PROVIDER NUMBER 102599715 REPORT SEQ. NUMBER 25 DATE 07/14/88 PAGE 2

NAME / RECIPIENT ID | SERVICE DATES FROM MM DD YY TO MM DD YY | DAYS OR UNITS | PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION | TOTAL BILLED | NON ALLOWED | TOTAL ALLOWED | SPENDDOWN | PATIENT LIABILITY | OTHER DEDUCTED CHARGES | PAID AMOUNT | EOB CODES

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    PAID CLAIMS
    MEDICAL

STUEART    ALLIE    M CO=29 RCC=     % CLAIM NUMBER=9888162061900 MED REC=0      DIAG=4019  SERV PHYS=102599715 ADMIT=
  0605913001        012788 012788   1 E A0010 00 AMBULANCE SERV BASE      8500   3750   4750   00   00   00   4750 365

  COINS=     .00   DED=        .00  TPL=     .00                          8500   3750   4750   00   00   00   4750

STUEART    ALLIE    M CO=29 RCC=     % CLAIM NUMBER=9888162061940 MED REC=0      DIAG=4019  SERV PHYS=102599715 ADMIT=
  0605913001        012388 012388   1 E A0010 00 AMBULANCE SERV BASE      8500   3750   4750   00   00   00   4750 365
                    012388 012388   1 E A0070 00 AMB. SERV., OXYGEN A     3000   2050    950   00   00   00    950 365

  COINS=     .00   DED=        .00  TPL=     .00                         11500   5800   5700   00   00   00   5700

STUEART    ALLIE    M CO=29 RCC=     % CLAIM NUMBER=9888162061950 MED REC=0      DIAG=4019  SERV PHYS=102599715 ADMIT=
  0605913001        012388 012388   1 E A0010 00 AMBULANCE SERV BASE      8500   3750   4750   00   00   00   4750 365

  COINS=     .00   DED=        .00  TPL=     .00                          8500   3750   4750   00   00   00   4750

     3      CLAIMS            4     MEDICAL                  *******     28500  13300  15200   00   00   00  15200
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STATE OF ARKANSAS

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

HEMPSTEAD COUNTY AMBULANCE SERV
PO BOX 1171
HOPE AR 71801

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PROVIDER NUMBER 102599715          REPORT SEQ. NUMBER   24         R/A NUMBER   587401
                                                                    DATE  07/07/88    PAGE  5

NAME / RECIPIENT ID | SERVICE DATES FROM MM DD YY  TO MM DD YY | DAYS OR UNITS | PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION | TOTAL BILLED | NON ALLOWED | TOTAL ALLOWED | SPENDDOWN | PATIENT LIABILITY | OTHER DEDUCTED CHARGES | PAID AMOUNT | EOB CODES

   DENIED CLAIMS
   PROFESSIONAL CROSSOVER

GHILARDI      JOHN         J              CLAIM NUMBER=1088182011351  DIAG=     MED REC=          SERV PHYS=             EOB=250
  323055686C     050888 050888    1 9 A0010                      1322      1322        00        00        00      00       00 250

  COINS=    13.22  DED=      .00  TPL=      .00                   661       661        00        00        00      00       00
GHILARDI      JOHN         J              CLAIM NUMBER=1088182011352  DIAG=     MED REC=          SERV PHYS=             EOB=250
  323055686C     050888 050888   35 9 A0010                      1071      1071        00        00        00      00       00 250

  COINS=    10.71  DED=      .00  TPL=      .00                   536       536        00        00        00      00       00

     2       CLAIMS                 PROFESSIONAL CROSSOVER   *******       1197        00        00              00
                                                                 1197                            00                 00


  ****-->    TOTAL DENIED CLAIMS               3 CLAIMS                   96.97                 .00            .00
                                                                 96.97               .00                 .00                .00
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STATE OF ARKANSAS

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

HEMPSTEAD COUNTY AMBULANCE SERV
PO BOX 1171
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PROVIDER NUMBER 102599715          REPORT SEQ. NUMBER   24         R/A NUMBER   587401
                                                                    DATE  07/07/88    PAGE  4

NAME / RECIPIENT ID | SERVICE DATES FROM MM DD YY  TO MM DD YY | DAYS OR UNITS | PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION | TOTAL BILLED | NON ALLOWED | TOTAL ALLOWED | SPENDDOWN | PATIENT LIABILITY | OTHER DEDUCTED CHARGES | PAID AMOUNT | EOB CODES

   DENIED CLAIMS
   MEDICAL

VANSCOY       MARY         L              CLAIM NUMBER=9888162061920  DIAG=7800  MED REC=0     SERV PHYS=102599715  EOB=
  0962559001     041088 041088    1 1 A0010 00                   8500      8500        00        00        00      00       00 164

  COINS=      .00  DED=      .00  TPL=      .00                  8500      8500        00        00        00      00       00

     1       CLAIMS         1       MEDICAL                  *******       8500                  00              00
                                                                 8500                00                  00                 00
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PAGE 2

NAME RECIPIENT ID	SERVICE DATES FROM MM DD YY	TO MM DD YY	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
PAID CLAIMS												
MEDICAL												
HENDRIX CORY	D CO=29	RCC=	%	CLAIM NUMBER=9888166067450 MED	REC=0	DIAG=E819		SERV PHYS=102599715		ADMIT=		
0734254201	051388	051388	1 E	A0010 00 AMBULANCE SERV BASE	8500	3750	4750	00	00	00	4750	365
	051388	051388	1 E	A0070 00 AMB. SERV., OXYGEN A	3000	2050	950	00	00	00	950	365
	051388	051388	1 E	A0215 00	2000	2000	00	00	00	00	00	41
	051388	051388	1 E	A0215 00	2000	2000	00	00	00	00	00	41
COINS= .00	DED=		.00	TPL= .00	15500	9800	5700	00	00	00	5700	
1	CLAIMS		4	MEDICAL *******	15500	9800	5700	00	00	00	5700	

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NAME RECIPIENT ID	SERVICE DATES FROM MM DD YY	TO MM DD YY	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
CLAIMS IN PROCESS - THESE CLAIMS ARE BEING PROCESSED AS LISTED												
PROFESSIONAL												
0613304001 GILLARD		BREND		072488 072488 ICN 9888216062960	415.00	MEDICAL	RECORD = 0					14
0583001201 GLENN		TYKES		070688 070688 ICN 9888214083600	155.00	MEDICAL	RECORD = 0					14
0962559001 VANSCOY		MARY	L	042388 042388 ICN 9888216062980	85.00	MEDICAL	RECORD = 0					14
0923044001 COLLINS		ALLI	A	062988 062988 ICN 1088224003853	6.61	MEDICAL	RECORD =					260
4	CLAIMS			PROFESSIONAL	*******	66161						
****-->	TOTAL PENDING CLAIMS			4 CLAIMS		661.61						

Marked
in book

STATE OF ARKANSAS

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

HEMPSTEAD COUNTY AMBULANCE SERV
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PROVIDER NUMBER 102599715

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R/A NUMBER 612575

DATE 08/18/88 PAGE 3

NAME RECIPIENT ID	SERVICE DATES FROM MM DD YY	SERVICE DATES TO MM DD YY	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
DENIED CLAIMS												
MEDICAL												
GILLARD BRENDA				CLAIM NUM=9888216062950	DIAG=E8939	MRN=0			SERV PHYS=102599715			EOB=154
0613304001	072488	072488	1 E	A0010 00 AMBULANCE SERV BASE	8500	8500	00	00	00	00	00	154
	072488	072488	1 E	A0070 00 AMB. SERV., OXYGEN A	3000	3000	00	00	00	00	00	154
	072488	072488	1 E	A0215 00	2000	2000	00	00	00	00	00	41
COINS=	.00	DED=	.00	TPL= .00	13500	13500	00	00	00	00	00	
MC S				CLAIM NUM=9888216062940	DIAG=E888	MRN=0			SERV PHYS=102599715			EOB=252 154
0916575001	071988	071988	1 E	A0010 00 AMBULANCE SERV BASE	8500	8500	00	00	00	00	00	252
COINS=	.00	DED=	.00	TPL= .00	8500	8500	00	00	00	00	00	
VA L				CLAIM NUM=9888216062970	DIAG=7800	MRN=0			SERV PHYS=102599715			EOB=252 154
0962559001	041088	041088	1 E	A0010 00 AMBULANCE SERV BASE	8500	8500	00	00	00	00	00	252
COINS=	.00	DED=	.00	TPL= .00	8500	8500	00	00	00	00	00	
WARREN JESSIE J				CLAIM NUM=9888216062920	DIAG=8738	MRN=0			SERV PHYS=102599715			EOB=154
0165775001	042388	042388	1 E	A0010 00 AMBULANCE SERV BASE	8500	8500	00	00	00	00	00	154
	042388	042388	1 E	A0020 00 AMB SERV PER MILE LO	1400	1400	00	00	00	00	00	154
	042388	042388	1 E	A0215 00	2000	2000	00	00	00	00	00	41
	042388	042388	1 E	A0215 00	2000	2000	00	00	00	00	00	41
COINS=	.00	DED=	.00	TPL= .00	13900	13900	00	00	00	00	00	
4 CLAIMS			9	MEDICAL *******	44400	44400	00	00	00	00	00	
****--> TOTAL DENIED CLAIMS				4 CLAIMS	444.00	444.00	.00	.00	.00	.00	.00	

Senator Pryor. All right. First, I have an announcement, and then I'm going to call on some more. Our very good friend who had to leave is Representative John Lipton who wanted me to announce at this time that this coming Thursday, September 1 at 10 a.m., the Arkansas General Assembly, the legislative council, will hold a meeting of the council, and the topic will the be rural health care. And any and all of you—I guess the room is large enough there. That will be September 1 according to Representative Lipton at 10 o'clock at the State Capitol Building in Little Rock.

I also promised earlier, if we had the opportunity, we would call on Mr. Gary Hughes of the Arkansas Home Health Association. Is Mr. Hughes still in our audience? Gary, would you like to make a statement here?

STATEMENT OF GARY L. HUGHES, ADMINISTRATOR, ARKANSAS HOME HEALTH AGENCY, PRESIDENT, ARKANSAS ASSOCIATION OF HOME HEALTH AGENCIES, LITTLE ROCK, AR

Mr. Hughes. Senator Pryor, thank you for this opportunity to be able to speak today.

I am administrator of the Arkansas Home Health Agency. We're a skilled home care agency that provides skilled nursing care, physical therapy, speech therapy, and home health aide services in the home. We serve several rural counties in northeast Arkansas. I am currently the president of the Arkansas Association of Home Health Agencies. And I'm also an elected mayor of a small community in northeast Arkansas.

Having these responsibilities, I have a genuine concern for the problems facing rural health care. I believe the problems are real and the problems are serious.

When hospitals fall, it has a tremendous impact on their community. I know from personal experience because I live in Forrest City and have watched hospitals in surrounding counties fall like dominoes. The Brinkley Hospital closed in July 1987; the Marianna Hospital closed last week; the McCrory Hospital has announced it will soon close; other hospitals have mentioned financial hardships. All these hospitals are within a 30-mile radius of my home. Many are in areas we provide home health care services. The hospitals are failing in areas where unemployment is high and economic conditions are poor.

I live in St. Francis County. We have led the State in unemployment for 20 consecutive months. St. Francis County topped 30 percent in May. Figures released just yesterday show July unemployment was 27 percent. Lee County was second on the list with 22.7 percent. Woodruff County unemployment was 13.4 percent. These are the same areas that have the hospitals that are struggling.

The point I want to make is: How are these areas going to come out of their economic distress now that they no longer have a local hospital? When prospective industry comes to visit our communities, one of the most important things they want to see are the available health care facilities. When we say that our local hospital was forced to close, we are going to have a hard time attracting new industry. Without a local rural hospital, it is going to be almost impossible to see economic progress again.

I would like to make just a couple of comments to stress the increased importance of home care services during these distressed times. The demand for home health care services has increased significantly since the DRG system was implemented for hospitals. We have found that patients are discharged quicker and sicker than ever before. Therefore, the need for quality home care agencies has become even more important during the past few years. We now perform more complex procedures on a routine basis. IV therapy, total parental nutrition, IV pain medication, and enteral nutrition are just a few of the more complex procedures now performed safely and effectively at home.

When hospitals close and physicians begin to leave town, the only health care delivery system that remains many times is home health care. We need Washington's and the State of Arkansas' continued support to assure that the last link in health care system is not destroyed. Without home health care, many people would be unable to remain in the comfort of their own home; they would be forced to be institutionalized. And the main goal and purpose of home health care is to keep people in a place where they are happy—in their own home.

We need the home health care benefit expanded to help those who fall through the cracks—those who due to chronic conditions find themselves ineligible to receive home health care. Many people who are completely dependent on others for their activities of daily living find themselves unable to receive home health care. If the home care benefit was expanded, thousands more could remain in their own home and be with their family where they could live a more fruitful and productive life.

The reimbursement system for home health care services should be looked at very closely. Today, we are reimbursed 17 percent less for a skilled nursing visit than we received in 1980. Since 1980, we have taken a 17-percent cut in reimbursement. Home health care agencies cannot continue to provide quality service without adequate reimbursement. We need someone to understand the increasing costs associated with operating a home care agency and provide an adequate reimbursement so we can continue to operate.

I appreciate the opportunity you have given me to voice my concerns and comments. [Applause.]

Senator PRYOR. Thank you, Gary. That's a very fine statement.

Before I call on Mr. Frank Butts, let me ask, if I might, and this is a little out of the ordinary. Franklin Montgomery of the Lee Memorial Hospital, would it be possible for you to answer one more question that I failed to ask you awhile ago? And let the record show that I have gone to the audience to recall one of our witnesses, Mr. Franklin Montgomery from Marianna.

And here's the question: If the reimbursement for Medicare, Franklin, at Marianna, the Lee County Hospital, if it were for the same dollars that were received, let's say, in Little Rock for the same number of days stay and the same procedures, would the Marianna Hospital still be open?

Mr. MONTGOMERY. It would still be open, yes, sir. [Applause.]

Senator PRYOR. I think that's my only question. I meant to ask you that awhile ago.

Mr. MONTGOMERY. Very good. Thank you.

Senator Pryor. Now I'm going to ask for Mr. Frank Butts. He's with the Frost & Co., an accounting firm. Frank, I think that you are doing a study now, is this correct?

Mr. Butts. Yes.

Senator Pryor. If you will identify yourself, and we will put your statement, your full statement, in the record.

STATEMENT OF FRANK M. BUTTS, CPA, PARTNER, FROST & CO., LITTLE ROCK, AR

Mr. Butts. OK. Yes, sir.

We, at the present time, are going through and examining the financial status of 85 acute care hospitals, which are all of the acute care hospitals in the State of Arkansas, from 1983 through 1987. And this study is comparing their actual costs that they've incurred and to what they have been reimbursed on both Medicare and Medicaid.

Senator Pryor. Now, when will this study be completed?

Mr. Butts. The study basically incorporates the review of the 85 acute care hospitals in the State of Arkansas from 1983 through 1987. And this study compares them on bed size as well as by regions of the State. It will, also, when we have completed the study, show what the actual cost per patient day for Medicaid is and what they—the hospitals—have been reimbursed per day, as well as what the cost for discharge for Medicare is and what they—the hospitals—have been reimbursed.

Preliminary—I will share this with you, Senator. The costs being reimbursed to the hospitals today in 1987 [sic] is approximately 80 percent of what they were reimbursed in 1984, which represents about 60 percent of the costs of delivering the care to the patient.

Senator Pryor. Now, is this the costs to the rural hospitals under DRG or to the urban?

Mr. Butts. To all the hospitals in the State.

Senator Pryor. To all hospitals?

Mr. Butts. All of the hospitals in the State.

Senator Pryor. Eighty percent less today?

Mr. Butts. That's right.

Senator Pryor. Thus far your story has indicated, I mean your study.

Mr. Butts. And I didn't know if you were aware, but the State recently came out that the Medicaid Program had an excess of $16.2 million in the fund last month, I believe. And if some of that money would have been reimbursed to some of the hospitals that have closed, I think some of them would still be open today, too.

Senator Pryor. Well, now, when will all this study be completed and ready for——

Mr. Butts. It's scheduled by September 2.

Senator Pryor. I would hope to have a copy of it.

Mr. Butts. Yes, sir. I'd be glad to——

Senator Pryor. I will share with my colleagues in the Senate.

Mr. Butts. With that, I would, if I may, read my statement for you.

First of all, I want to thank you for the opportunity to present some facts before the committee.

By way of introduction, I'm a certified public accountant and a partner with Frost & Co., a regional accounting firm located in Little Rock, AR. I have specialized in auditing and reimbursement consulting of health care facilities for over 18 years and have previously served as a chief financial officer of a national health care hospital proprietary chain. Presently, I serve as partner in-charge of over 30 health care facilities in Arkansas and the southeastern portion of our country. The thoughts and comments I am about to share with you are a result of several years experience in serving health care clientele and observations made concerning the critical situation that some of our rural health care facilities now are faced with throughout our State and our country.

In the late 1960's, the Federal Government created a health care reimbursement system and methodology whereby the health care needs of our aging population were to be cared for through a nationally funded program called Medicare. Since we are all familiar with several of the changes in this system since the late 1960's, I will not detail them here, but will mention that it was the objective of the Medicare and Medicaid programs to provide adequate health care coverage to all patients including all elements, urban and rural, of our communities. Every employed citizen in our country has been paying for this coverage through increased payroll deductions, FICA, since that date.

Over the past years, I have seen our health care communities grow from infancy through a mature stage to the present status of a dying industry. Yes, Senator, the health care industry is rapidly dying in today's rural America communities. The reasons for this are both complex and varied but still can be traced directly back to the change in the Medicare reimbursement system in 1983 to the prospective payment system methodology.

I am in the process of completing an engagement whereby we analyzed the financial status of all the acute care hospitals as it relates to Medicare and Medicaid reimbursement in the State of Arkansas. This study has revealed for the most part that rural hospitals in our State are rapidly approaching bankruptcy. While some of the reasons for this situation are directly related to outdated or inadequate management practices within some of these health care facilities, it appears that a significant part of their situation has been brought about by the prospective system by:

First of all, extensive review and retroactive denials of reimbursement to the rural providers by peer review organizations after a facility has rendered its services.

Second, differential in payment rates between rural and urban providers.

Third, aggressive and competitive audit environments by program intermediaries.

Fourth, inadequate financial considerations and planning of policy and administrative decisions by the Health Care Financing Administration.

In talking about the extensive review and retroactive denials, as stipulated under the Medicare prospective payment system, a provider review organization, known as PRO, was created to review and monitor the appropriateness of hospital admissions. Originally, the PRO was a review process to help the facilities better document and evaluate the true need for health care. However, this process has changed into a straight dictatorial process by the PRO, whereby an agency makes a decision on the need of an admission, for the most part, after treatment and discharge of the patient. If anything is missing in documentation, signatures or inadequate care are contained in the hospital's admission process, then that admission can be denied and thus reimbursement denied to the hospital. This has put a financial hardship on all sizes of the hospitals but, particularly, the small rural hospital. You see, in most cases, the small rural hospital does not have the financial ability to pay an experienced person for the time and effort required to properly monitor and document the hospital admissions that larger urban hospitals do on extraordinary levels. In addition, the review of a small rural hospital is easier for the PRO, and thus creates a situation whereby the PRO reviews a large percentage of admissions and directly relates to a larger denial of claims. The larger hospitals have the personnel, money, and time to appeal a denial, and this creates more time for the PRO and thus forces them to spend less time on the larger urban facilities.

Another problem with the PRO appears to be the competence level of the organization. Several physicians now question how a PRO can recruit qualified practicing physicians to perform these reviews. In recent months, we've all seen the PRO's in various regions cited by HCFA for inadequate staff. Common sense surely points out that a practicing physician wants to treat patients and practice quality medicine. Therefore, this leaves only a semi-retired or nonpracticing physician to perform the reviews which has created a quality medicine gap, in our country, with practicing physicians questioning the true ability of the PRO to perform qualified reviews. Physicians are concerned over extended reviews by the PRO's on their practices and thereby concerned over their ability to be outspoken against the PRO.

My recommendations for your committee are:

Eliminate the retroactive denial process for rural hospitals and create an education requirement for the small rural hospitals.

Limit the review process in smaller rural hospitals and have the PRO's concentrate on larger urban facilities. After all, this is where the majority of the reimbursement funds are expended.

Create a review process of the quality of review process by the PRO's. This will enforce the PRO's to employ qualified practicing physicians. Maybe possibly consider a denial of contractor payments to the PRO if certain deficiencies are revealed by their performance.

Eliminate the denial of documentational errors and restrict the denials only to quality health care issues.

On the payment differentials. As a prospective payment system was created, the urban and rural classifications were created. This stemmed, no doubt, from a previous recommendation and system in the prior Medicare Program whereby the comparison of large urban hospitals to small rural hospitals could not be adequately performed. However, this new payment system has moved the small rural hospital into direct competition with the large urban hospitals. Salaries for employees must now be at similar levels in order to attract the employees to the rural hospitals. There are even situations where rural hospitals must pay a premium to attract experienced employees. This creates even more of a financial strain on the rural hospital. Operational costs for rural hospitals are now directly tied to the performance requirements of large urban hospitals in order to compete for qualified, quality services offered by the hospital to attract potential patients.

The recommendation for this problem is simple: Remove the payment differential between rural and urban hospitals and do not discriminate and restrict the smaller hospitals in their ability to compete with the larger urban hospitals.

On the aggressive intermediaries—the Medicare Program created a process whereby the cost reports for participating programs were audited as well as the payment process for providers would be administered. The current financial environment of the administration, particularly HCFA, has created a situation where the intermediaries are competing for intermediary contracts. This has now placed the intermediary into a cost savings manager rather than an administrator of the program and eliminated their ability to adequately monitor and administer the Medicare Program. Examples of this atmosphere are becoming very commonplace, such as:

Measurement of the contractors' performance to a cost savings intermediary cost ratio. Similar to previous ratios by IRS agents, the intermediaries are measured by how much money they save the program to their cost of administering the claims payment and cost report audits. Even though HCFA verbally acknowledged these ratios, the publication of them or written acknowledgements are not made.

Senator PRYOR. Frank, I hate to do this, but I'm going to have to interrupt. Do you have much longer on your statement? If you do, I'll let you put that in the record because I do have one more commitment to call on someone else, and then I'm going to open this up. But I'm very impressed with the work you've done on this. If you want to conclude now, you may.

Mr. BUTTS. OK.

Just simply to say that there are certain recommendations that need to be taken care with the intermediaries to create a working environment with the hospitals.

On the financial considerations, we need to consider the fact that the promises we make to the small rural hospitals—an example of last year when we told them "You are going to get a 2.9-percent increase." Actually, it worked out so that it's a 7-percent decrease, because we took away their capital cost.

Senator PRYOR. That's a very good point.

Mr. BUTTS. And then the final thing I would like to say, Senator, is that we need to do something now, not tomorrow, not next week. [Applause.]

[The prepared statement of Mr. Butts follows:]

RURAL HEALTH CARE

by

FRANK M. BUTTS, CPA

PARTNER
FROST & COMPANY
LITTLE ROCK, ARKANSAS

TESTIMONY PRESENTED TO SENATE SPECIAL COMMITTEE
ON AGING

AUGUST 30, 1988

MR. CHAIRMAN AND MEMBERS OF THE SPECIAL COMMITTEE ON AGING,

THANK YOU FOR YOUR INVITATION TO PRESENT AND SHARE SOME THOUGHTS ON THE RURAL HEALTHCARE STATUS IN ARKANSAS. IT IS AN HONOR TO BE HERE BEFORE THIS COMMITTEE. BY WAY OF INTRODUCTION, I AM A CERTIFIED PUBLIC ACCOUNTANT AND A PARTNER WITH FROST & COMPANY, A REGIONAL ACCOUNTING FIRM, LOCATED IN LITTLE ROCK, ARKANSAS. I HAVE SPECIALIZED IN AUDITING AND REIMBURSEMENT CONSULTING OF HEALTHCARE FACILITIES FOR OVER EIGHTEEN YEARS AND HAVE PREVIOUSLY SERVED AS A CHIEF FINANCIAL OFFICER OF A NATIONAL HEALTHCARE PROPRIETARY CHAIN. PRESENTLY, I SERVE AS THE PARTNER IN-CHARGE OF OVER 30 HEALTHCARE FACILITIES IN ARKANSAS AND THE SOUTHEASTERN PORTION OF OUR COUNTRY. THE THOUGHTS AND COMMENTS I AM ABOUT TO SHARE WITH YOU ARE A RESULT OF SEVERAL YEARS OF EXPERIENCE IN SERVING HEALTHCARE CLIENTELE AND OBSERVATIONS MADE CONCERNING THE CRITICAL SITUATION THAT SEVERAL OF OUR RURAL HEALTHCARE FACILITIES NOW ARE FORCED WITH THROUGHOUT OUR STATE AS WELL AS OUR COUNTRY.

IN THE LATE 1960'S OUR FEDERAL GOVERNMENT CREATED A HEALTHCARE REIMBURSEMENT SYSTEM AND METHODOLOGY WHEREBY THE HEALTHCARE NEEDS OF AN AGING POPULATION WERE TO BE CARED FOR THROUGH A NATIONALLY FUNDED PROGRAM CALLED MEDICARE. SINCE WE ARE ALL FAMILIAR WITH SEVERAL OF THE CHANGES IN THE SYSTEM SINCE THE LATE 1960'S, I WILL NOT DETAIL THEM HERE, BUT WILL MENTION THAT IT WAS THE OBJECTIVE OF THE MEDICARE PROGRAM TO PROGRAM TO PROVIDE ADEQUATE HEALTHCARE COVERAGE OF ALL ELEMENTS (URBAN AND RURAL) OF OUR COMMUNITIES. EVERY EMPLOYED CITIZEN OF OUR COUNTRY HAS BEEN PAYING FOR THIS COVERAGE THROUGH THE INCREASED PAYROLL DEDUCTIONS (FICA) SINCE THAT DATE.

OVER THE PAST YEARS, I HAVE SEEN OUR HEALTHCARE COMMUNITIES GROW FROM THE INFANCY THROUGH A MATURE STAGE TO THE PRESENT STATUS OF A DYING INDUSTRY.

YES, MR. CHAIRMAN, THE HEALTHCARE INDUSTRY IS RAPIDLY DYING IN TODAY'S RURAL AMERICA COMMUNITIES. THE REASONS FOR THIS ARE BOTH COMPLEX AND VARIED, BUT STILL CAN BE TRACED DIRECTLY BACK TO THE CHANGE IN THE MEDICARE REIMBURSEMENT SYSTEM IN 1983 TO THE PROSPECTIVE PAYMENT SYSTEM METHODOLOGY.

I AM IN THE PROCESS OF COMPLETING AN ENGAGEMENT WHEREBY WE ANALYZED THE FINANCIAL STATUS OF ALL THE ACCUTE CARE HOSPITALS AS IT RELATES TO MEDICARE AND MEDICAID REIMBURSEMENT IN THE STATE OF ARKANSAS. THIS STUDY HAS REVEALED THAT FOR THE MOST PART, THE RURAL HOSPITALS IN OUR STATE ARE RAPIDLY APPROACHING BANKRUPTCY. WHILE SOME OF THE REASONS FOR THIS SITUATION ARE DIRECTLY RELATED TO OUTDATED, OR INADEQUATE MANAGEMENT PRACTICES WITHIN SOME OF THE HEALTHCARE FACILITIES, IT APPEARS THAT A SIGNIFICANT PART OF THEIR SITUATION HAS BEEN BROUGHT ABOUT BY THE PROSPECTIVE PAYMENT SYSTEM BY:

(A) EXTENSIVE REVIEW AND RETROACTIVE DENIALS OF REIMBURSEMENT TO THE RURAL PROVIDERS BY REVIEW ORGANIZATION (PRO'S) AFTER A FACILITY RENDERED THEIR SERVICES.

(B) DIFFERENTIAL IN PROSPECTIVE PAYMENT RATES BETWEEN RURAL AND URBAN PROVIDERS.

(C) AGGRESSIVE AND COMPETITIVE AUDIT ENVIRONMENTS BY PROGRAM INTERMEDIARIES.

(D) INADEQUATE FINANCIAL CONSIDERATIONS AND PLANNING OF POLICY AND ADMINISTRATIVE DECISIONS BY THE HEALTHCARE FINANCING ADMINISTRATION (HCFA).

EXTENSIVE REVIEW AND RETROACTIVE DENIALS

AS STIPULATED UNDER THE PROSPECTIVE PAYMENT SYSTEM, A PROVIDER REVIEW ORGANIZATION (PRO) WAS CREATED TO REVIEW AND MONITOR THE APPROPRIATENESS OF HOSPITAL ADMISSIONS. ORIGINALLY, THE PRO WAS A REVIEW PROCESS TO HELP THE FACILITIES BETTER DOCUMENT AND EVALUATE THE "TRUE" NEED FOR HEALTHCARE. HOWEVER, THIS PROCESS CHANGED INTO A STRAIGHT DICTATORIAL PROCESS BY THE PRO WHEREBY AN AGENCY MAKES A DECISION ON THE MEDICAL NEED OF AN ADMISSION (FOR MOST PART AFTER TREATMENT AND DISCHARGE OF THE PATIENT). IF ANYTHING IS MISSING IN DOCUMENTATION, SIGNATURES OR INADEQUATE CARE ARE CONTAINED IN THE HOSPITAL'S ADMISSION PROCESS, THEN THAT ADMISSION CAN BE DENIED AND THUS REIMBURSEMENT DENIED THE HOSPITAL. THIS HAS PUT A HARDSHIP ON ALL SIZES OF HOSPITALS, BUT PARTICULARLY THE SAME RURAL HOSPITAL. YOU SEE IN MOST CASES A SMALL RURAL HOSPITAL DOES NOT HAVE THE FINANCIAL ABILITY TO PAY AN EXPERIENCED PERSON FOR THE TIME AND EFFORT REQUIRED TO PROPERLY MONITOR AND DOCUMENT HOSPITAL ADMISSIONS THAT LARGER URBAN HOSPITALS DO TO EXTRAORDINARY LEVELS. IN ADDITION, THE REVIEW OF A SMALLER RURAL HOSPITAL IS EASIER FOR THE PRO AND THIS CREATES A SITUATION WHEREBY THE PRO REVIEWS A LARGER PERCENTAGE OF ADMISSIONS AND DIRECTLY RELATES TO A LARGER DENIAL OF CLAIMS. THE LARGER HOSPITALS HAVE THE PERSONNEL, MONEY AND TIME TO APPEAL A DENIAL AND THIS CREATES MORE TIME FOR THE PRO AND THUS FORCES THEM TO SPEND LESS TIME ON THE LARGER URBAN FACILITIES.

ANOTHER PROBLEM WITH THE PRO APPEARS TO BE WITH THE COMPETENCE LEVEL OF THE ORGANIZATION. SEVERAL PHYSICIANS NOW QUESTION HOW A PRO CAN RECRUIT QUALIFIED PRACTICING PHYSICIANS TO PERFORM THESE REVIEWS. IN RECENT MONTHS WE HAVE ALL SEEN

THE PRO'S IN VARIOUS REGIONS CITED BY HCFA FOR INADEQUATE STAFF. COMMON SENSE SURELY POINTS OUT THAT A PRACTICING PHYSICIAN WANTS TO TREAT PATIENTS AND PRACTICE QUALITY MEDICARE. THEREFORE, THIS LEAVES ONLY SEMI-RETIRED OR NON-PRACTICING PHYSICIANS TO PERFORM REVIEWS, WHICH HAS CREATED A "QUALITY MEDICARE" GAP IN OUR COUNTRY WITH PRACTICING PHYSICIANS QUESTIONING THE TRUE ABILITY OF THE PRO TO PERFORM QUALIFIED REVIEWS. PHYSICIANS ARE CONCERNED OVER EXTENDED REVIEWS BY THE PRO'S ON THEIR PRACTICES AND THEREBY CONCERNED OVER THEIR ABILITY TO BE OUTSPOKEN ABOUT THE PRO.

MY RECOMMENDATIONS FOR THIS COMMITTEE ON THIS PROBLEM ARE:

(A) ELIMINATE THE RETROACTIVE DENIAL PROCESS FOR RURAL HOSPITALS AND CREATE AN EVALUATION REQUIREMENT FOR THE SMALLER RURAL HOSPITALS.

(B) LIMIT THE REVIEW PROCESS IN SMALLER RURAL HOSPITALS AND HAVE THE PRO'S CONCENTRATE ON THE LARGER FACILITIES. AFTER ALL, THIS IS WHERE THE MAJORITY OF REIMBURSEMENT FUNDS ARE EXPENDED.

(C) CREATE A REVIEW PROCESS OF THE QUALITY OF REVIEW PROCESS BY THE PRO'S. THIS WILL FORCE THE PRO'S TO EMPLOY QUALIFIED PRACTICING PHYSICIANS. MAYBE CONSIDER A DENIAL OF CONTRACTOR PAYMENTS TO THE PRO IF CERTAIN DEFICIANCES ARE REVEALED.

(D) ELIMINATE THE DENIAL OF DOCUMENTATIONAL ERRORS AND RESTRICT THE DENIALS ONLY TO "QUALITY HEALTHCARE" ISSUES.

PAYMENT DIFFERENTIALS

AS THE PROSPECTIVE PAYMENT SYSTEM WAS CREATED, THE URBAN AND RURAL CLASSIFICATIONS WERE CREATED. THIS STEMMED, NO DOUBT, FROM A PREVIOUS RECOMMENDATION AND SYSTEM IN THE PRIOR MEDICARE PROGRAM WHEREBY THE COMPARISON OF LARGE URBAN HOSPITALS TO SMALL RURAL HOSPITALS COULD NOT BE ADEQUATELY PERFORMED. HOWEVER, THIS NEW PAYMENT SYSTEM HAS MOVED THE SMALL RURAL HOSPITAL INTO DIRECT COMPETITION WITH THE LARGE URBAN HOSPITALS. SALARIES FOR EMPLOYEES MUST NOW BE AT SIMILAR LEVELS IN ORDER TO ATTRACT THE EMPLOYEES TO THE RURAL HOSPITAL. THERE ARE EVEN SEVERAL SITUATIONS WHERE RURAL HOSPITALS MUST PAY A PREMIUM TO ATTRACT THE EXPERIENCED EMPLOYEES. THIS CREATES EVEN MORE OF A FINANCIAL STRAIN ON THE RURAL HOSPITAL. OPERATIONAL COSTS FOR RURAL HOSPITALS ARE NOW DIRECTLY TIED TO THE PERFORMANCE REQUIREMENTS OF LARGER URBAN HOSPITALS IN ORDER TO COMPETE FOR QUALITY SERVICES OFFERED BY THE HOSPITAL TO ATTRACT POTENTIAL PATIENTS.

THE RECOMMENDATION FOR THIS PROBLEM IS SIMPLE:

- REMOVE THE PAYMENT DIFFERENTIAL BETWEEN RURAL AND URBAN HOSPITALS AND DO NOT DISCRIMINATE AND RESTRICT THE SMALLER HOSPITALS IN THEIR ABILITY TO COMPETE WITH THE LARGER URBAN HOSPITALS.

AGGRESSIVE INTERMEDIARIES

THE MEDICARE PROGRAM CREATED A PROCESS WHEREBY THE COST REPORTS FOR PARTICIPATING PROGRAMS WERE AUDITED AS WELL AS THE PAYMENT PROCESS FOR PROVIDERS WOULD BE ADMINISTERED. THE CURRENT FINANCIAL ENVIRONMENT OF THE ADMINISTRATION, PARTICULARLY HCFA, HAS CREATED A SITUATION WHERE THE INTERMEDIARIES ARE COMPETING FOR THE INTERMEDIARY CONTRACTS. THIS HAS NOW PLACED THE INTERMEDIARY INTO A COST SAVINGS MANAGER RATHER THAN AN ADMINISTRATOR OF THE PROGRAM AND ELIMINATED THEIR ABILITY TO ADEQUATELY MONITOR AND ADMINISTER THE MEDICARE PROGRAM. EXAMPLES OF THIS ATMOSPHERE ARE BECOMING VERY COMMONPLACE, SUCH AS:

(A) MEASUREMENT OF THE CONTRACTORS PERFORMANCE TO A COST SAVINGS TO INTERMEDIARY COST RATIO. SIMILAR TO PREVIOUS RATIOS BY IRS AGENTS, THE INTERMEDIARIES ARE MEASURED BY HOW MUCH MONEY THEY SAVE THE PROGRAM TO THEIR COST OF ADMINISTERING THE CLAIMS PAYMENT AND COST REPORT AUDITS. EVEN THOUGH HCFA VERBALLY ACKNOWLEDGES THESE RATIOS, THE PUBLICATION OF THEM OR PUBLIC WRITTEN ACKNOWLEDGEMENTS ARE NOT MADE.

(B) DELAY OF REIMBURSEMENT TO HOSPITALS IN ORDER TO SAVE ON FUNDS. SEVERAL HOSPITALS CANNOT GET THEIR APPEALS OF REIMBURSEMENT ISSUES EVEN HEARD THROUGH THE APPEAL PROCESS. THE INTERMEDIARIES SIMPLY DO NOT HAVE SUFFICIENT TIME TO PROVIDE AN EFFICIENT APPEAL PROCESS. OFTEN THE PROVIDER MUST WAIT YEARS TO RESOLVE ISSUES.

AND IN THE MEANTIME, THEY (THE HOSPITALS) ARE DENIED REIMBURSEMENT AND FORCED TO EXPEND FUNDS TO RECEIVE LEGITIMATE REIMBURSEMENT.

TO HELP THE RURAL HOSPITALS THE INTERMEDIARIES MUST:

(A) CREATE A WORKING ENVIRONMENT WITH THE HOSPITALS AND NOT BE EVALUATED ON A PROGRAM COST SAVING RATIO.

(B) HAVE AVAILABLE ADEQUATE FUNDS TO PROPERLY ADMINISTER PROGRAM ISSUES.

INADEQUATE FINANCIAL CONSIDERATIONS

IN TODAYS RURAL HOSPITALS EACH DAY BRINGS MORE REGULATIONS AND CONTROL WITH THE RESULT BEING LESS REIMBURSEMENT AND MORE FINANCIAL STRAINS IMPOSED ON THE RURAL HOSPITALS. SEVERAL OF THE NEW REGULATIONS HAVE CREATED CONFLICTS WITHIN THEMSELVES. THESE NEW REGULATIONS APPEAR TO BE THE RESULT OF BUDGET ANALYSISTS WITHIN HCFA AND NOT EXPERIENCED HEALTH PROGRAM ANALYSISTS WHO MEASURE TRUE IMPACTS OF NEW REGULATIONS ON THE HOSPITALS.

CERTAIN ISSUES HERE ARE:

(A) ARBITRARY REDUCTIONS OF REIMBURSEMENT TO HOSPITALS. IN 1986, ACFA CREATED A REDUCTION METHODOLOGY TO THE CAPITAL REIMBURSEMENT RECEIVED BY HOSPITALS. THIS REDUCTION IS APPROACHING THE 15% LEVEL WITHOUT ANY CORRESPONDING CHANGE TO THE OPERATING OR DRG PAYMENT TO COMPENSATE FOR THIS DEDUCTION. THIS REDUCTION IS SCHEDULED TO INCREASE EVEN MORE IN FUTURE YEARS. THIS REDUCTION IS WITHOUT ANY SOUND FINANCIAL OPERATING BASIS. THE ARBITRARY REDUCTION OF CAPITAL PAYMENTS HAS FORCED ADDITIONAL FINANCIAL STRAINS ON RURAL AND URBAN HOSPITALS. THESE REDUCTIONS HAVE ALSO BEEN MADE RETROACTIVE TO PRIOR FINANCIAL PERIODS (i.e. - DECEMBER 1987 MADE REDUCTIONS BACK TO OCTOBER 1, 1987). THIS SIMPLY CREATES FINANCIAL HAVOC FOR THE HOSPITAL WHEN PREVIOUS FUNDS WERE EXPENDED BASED UPON FINANCIAL FORECASTS MADE ON EXISTING REGULATIONS ONLY TO BE MADE OUTDATED AND UNREALIABLE TO THE HOSPITALS MANAGEMENT. ARBITRARY REDUCTIONS OF REIMBURSEMENT TO THE HOSPITALS DOES NOT PROVIDE STABLE FINANCIAL ENVIRONMENTS. YOU CAN'T IGNORE COSTS OF TREATING PATIENTS BY NOT PAYING FOR THEM.

(B) CREATION OF NEW PAYMENT CRITERIA SUCH AS PAYMENT SCREEN LEVELS FOR OUTPATIENT SERVICES HAS NOT BEEN ADEQUATELY EVALUATED FOR RURAL HOSPITALS. THE PAYMENT FOR SERVICE BASED UPON RATES PREVIOUSLY PAID FOR SERVICES WITH ARBITRARY PRICE LEVEL DEDUCTIONS FAILS TO RECOGNIZE THE TRUE COST OF PROVIDING THESE SERVICES. IN LARGER COMMUNITIES THIS METHODOLOGY HAS MERIT WHERE VOLUME CAN LOWER COST (PAYMENT) PER SERVICE. BUT IN A RURAL ENVIRONMENT, VOLUME LEVELS ARE GOVERNED MORE BY TRUE NEED OF THE SERVICE AND THUS BECOME ALMOST FIXED IN COST LEVELS. THIS REQUIRES A TRUE COST BASIS PAYMENT LEVEL THAN A FEE (SCREEN) PAYMENT BASIS.

(C) FAILURE OF THE NEW SYSTEM TO RECOGNIZE THE NEED TO CHANGE PERFORMANCE EVALUATION CRITERIA USED IN SETTING PAYMENT LEVELS. AN EXAMPLE OF THIS IS WHEN THE NEW SYSTEM WENT INTO EFFECT THE COST PER PATIENT DAY ROSE GREATLY IN 1984. THIS STATISTIC IS USED BY HCFA IN SETTING THE DEDUCTIBLE LEVEL FOR MEDICARE PATIENTS AND THUS, WE SAW A GREAT RISE IN THE DEDUCTIBLE IN THAT YEAR. YET, THE SYSTEM FAILED TO CONSIDER THE FACT THAT WHEN VOLUME (PATIENT DAYS) WE DECREASED AS AN INCENTIVE TO CONTROL COSTS IN A HOSPITAL ADMISSION, THE COST PER DAY IS SIMPLY GOING TO INCREASE WHETHER OR NOT TOTAL OPERATING COSTS REMAINED LEVEL, INCREASED OR EVEN DECREASED. IT IS SIMPLY A MATHEMATICAL COMPUTATION; LOWER THE NUMBER OF DAYS AND THE COST PER DAY WILL INCREASE. YET NO CONSIDERATION WAS GIVEN TO THIS EFFECT AND THE DEDUCTIBLE WAS INCREASED. WHY?

THE HEALTH CARE FINANCING ADMINISTRATION MUST BE MADE TO TAKE INTO CONSIDERATION THE FINANCIAL IMPACTS OF ARBITRARY DECISIONS AND REGULATIONS BY TRULY MEASURING THE EFFECT OF THESE DECISIONS AND REGULATIONS ON THE HOSPITALS ABILITY TO PROVIDE ADEQUATE HEALTHCARE TO PROGRAM BENEFICIARIES AND NOT JUST BUDGET COST SAVINGS.

FINALLY, MR. CHAIRMAN, THE GOVERNMENT MUST PROVIDE LEADERSHIP AND DIRECT FINANCIAL ASSISTANCE TO THE RURAL HOSPITALS. WE HAVE SEEN THIS TAKE PLACE FOR OTHER INDUSTRIES (i.e. FARM RELIEF). REMEMBER THAT THE RURAL HOSPITAL IS ONE OF THE LARGEST EMPLOYERS IN RURAL AMERICA AND PROVIDES A TRUE SERVICE TO ALL AMERICANS NOT JUST A SELECT FEW.

JOB PROGRAMS FOR HIGHWAY CONSTRUCTION WAS CREATED A WHILE BACK AND SENATOR BYRD LED THE SENATE IN PASSING THE HIGHWAY BILL BY STATING THAT THE BILL "MEANT JOBS" TO AMERICA. YET, WE FORCE THE LARGEST EMPLOYERS TO CLOSE! IT DOESN'T MAKE SENSE.

IF WE CONTINUE TO FORCE THE RURAL HOSPITALS INTO FINANCIAL CLOSURES ONLY YOU AND I WILL BE AFFECTED IN THE FUTURE WHEN WE NEED THE MISSING HEALTHCARE FACILITIES. WHAT HAPPENS TOMORROW WHEN A RURAL PATIENT IS DENIED ACCESS TO A HOSPITAL AND DIES ON THE WAY TO AN URBAN HOSPITAL. WHO TELLS THE PATIENT'S FAMILY - IF WE ONLY HAD THE OTHER HOSPITAL, WE COULD HAVE SAVED HIM - I DON'T WANT TO BE THAT PERSON. DO YOU?

WE MUST PROVIDE HELP NOW TO THESE RURAL HOSPITALS AND STOP THE FINANCIAL DRAIN BEFORE IT IS TOO LATE.

Senator PRYOR. I agree with you, and I thank you very much. And I want to see the full report when you complete it. Thank you very, very much. A lot of work has gone into that. Thank you very much.

And now Dr. Maurice Elovitz of the Helena Hospital.

STATEMENT OF DR. MAURICE ELOVITZ

Dr. ELOVITZ. I must, indeed, be a rare bird in these parts. I'm a fully trained general surgeon, trained at Harvard, and spent some 30-odd years in the New England and Northeastern environment. I voluntarily came to Arkansas, came to the rural area, to engage in the practice of rural medicine for which I felt I was superbly trained.

I've been here for some 10 years serving both the counties of Phillips and Lee, and I have served as a staff surgeon at the Lee Memorial Hospital in Lee County. I continue and I will continue to maintain a presence in Lee County despite the closing of the hospital there. We're in the process now of purchasing tarps to use in our waiting room of our rented office, newly rented, in case we have to do emergency deliveries. We do make home health calls. We have used our stationwagon as an ambulance to speed patients to the Helena hospital in case of emergencies. I would like to continue to serve my patients, if you all would like me to continue to do so.

Senator PRYOR. How can we do that? How can we best encourage you to serve your patients in rural Arkansas?

Dr. ELOVITZ. I think that one of the key factors in doing this is not only to rely on home health care, the dissemination of general practitioners, but the encouragement of specialists to enter these areas. This will be successful to some extent. The notion that present practitioners are fully trained to cut, deliver, and cast, I think belongs to the 1930's. A certain amount of this can be done, but a certain amount of this must be done on site. I cite you an example of a week ago. I served as a triage officer at Helena Hospital. We had a five-car pileup; 17 people were involved. Two were dead on arrival; three were critically injured and required helicopter transfer after extensive resuscitation on the floor; the remainder were either admitted or discharged, as their care necessitated. I could do that at Helena Hospital with the facilities now. I no longer can do this at Lee Memorial Hospital.

Senator PRYOR. I wonder how many Harvard-educated physicians we have serving rural Arkansas? I think you may be the only one that I know of.

Dr. ELOVITZ. I believe that's so. I've never taken count.

Senator PRYOR. Well, for whatever it is worth, I, for one citizen of our State, am very flattered and honored to have you in our State. And we owe you a round of applause. Thank you very, very much. [Applause.]

Dr. ELOVITZ. Thank you, Senator.

Senator PRYOR. Ladies and gentlemen, for the next 5 or 6 minutes, the floor is open; and anyone who has a comment, get right up. This is your chance.

Member of the Audience. Senator Pryor, I'm an RN, I'm a DRG coordinator, and I'm a discharge planner in a hospital of 41 beds in a town of 5,000 people. We have five physicians. We're going to lose our hospitals and we're going to lose our doctors, but most of all, we're going to lose lives. [Applause.]

Senator **Pryor.** Thank you very much.

Yes, come right ahead, sir. Thank you very much.

I would like, if I could, to get all of your names so they will be in the record. We'll get yours in just a moment.

Yes, sir.

STATEMENT OF ABIJAH HUGHES

Mr. **Hughes.** Thank you very much.

Senator, my name is Abijah Hughes. I'm the administrator of Bull Shoals Community Hospital in the north central part of the State as you'll note. I have one thing to offer, and I do not want to take too much time because I wrote you a letter yesterday explaining everything.

I'm concerned primarily with the elderly, the poor, the indigent or near indigent. In 1983, when I first read the PPS, the prospective plan, I realized that by this time that we would be in deep trouble. Consequently, I made preparation and wrote a health maintenance organization. This organization was sanctioned by the commissioner of the State of Arkansas in 1985. Subsequent to that time, we've enrolled some 18 to 2,000 people, and we've been very successful in servicing our area for the working people and a supplement for the Medicare recipients. Now, we made application through HHS, through HCFA, for Federal certification and to sign a contract with HCPA for the Medicare recipient. I have made three trips to Washington, all of which I've had very much success and had a lot of good promises and said, "Say, you're doing a good job." And this is fine, and this has been 1 year since October 1987. They said, "We'll have this back to you soon." And then they discovered double negatives, dangling participles, and what have you, so we're still hanging on. With this approval, we could furnish all of our Medicare recipients in our part of the country free of charge, without any money whatsoever. Now, all I am asking now is a little bit of congressional help. If we can get that, we will prove to our part of the country that we can render good medical care. We have a 48-bed hospital, 11 full-time physicians, home health, durable medical equipment, three drug stores—everything that we need to cost the elderly people absolutely no money at all. I outlined this for you, and I do not care to take up too much of your time.

Thank you very kindly.

Senator **Pryor.** Mr. Hughes, I thank you. I've just——they tell me that your letter did come into us this morning. I have a copy of it. Any support that I can give you, I'll be glad to, and we'll be in communication with you about it.

Mr. **Hughes.** A telephone call would certainly help, sir.

Senator **Pryor.** Thank you. That call will be made.

And, now, let's see, do we have anyone else? Yes, right here.

Now, you've taught school in Jefferson County for 30 years, didn't you?

MEMBER of the AUDIENCE. Twenty-five.

Senator **PRYOR.** Twenty-five, almost thirty. Now, if you'll give your name for the record.

STATEMENT OF MARY KEECH

Ms. **KEECH.** I am Mary Keech. I'm a retired schoolteacher, English teacher, Dr. Waller's French teacher. But I'm not here as a retired teacher; I'm here to represent Dr. McFarland's eye surgery center. And I want to enter one positive note. We do furnish free transportation to elderly, indigent, and anybody in Arkansas who wants to have free eye screening and if they do need subsequent cataract surgery or have glaucoma and need that type of laser surgery, we will go to their doorstep, pick them up, carry them, almost literally, put them in the van, bring them back, buy their lunch. And this is something that I'm proud to be part of because we are really helping people who otherwise would have no other way to see a doctor. I wish more doctors could do this.

Senator **PRYOR.** Well, I wish there were more people like you.

Ms. **KEECH.** Well, thank you.

Senator **PRYOR.** Thank you. [Applause.]

Ms. **KEECH.** I really enjoy what I do.

Senator **PRYOR.** Thank you very, very much.

Yes, sir. Right here and then right over here. Now, if we give our names and where we're from so Senator Melcher and other members of the committee in Washington will see that we're not just faking this hearing.

STATEMENT OF DR. KENNETH MEACHAM

Dr. **MEACHAM.** Thank you, Senator. I'm Kenneth Meacham from Searcy, AR. I'm a urologist and kidney and bladder surgeon. I have 13 years of experience in practice in our area. I also serve on the board of trustees of the Baptist Medical System in Little Rock and also the State health department.

Earlier you asked a question, and I'd like to direct it to you because I don't know the answer. It seems that Arkansas residents pay the same Medicare premium. We all pay the same Social Security rate, that is all of us here are covered. And yet, you asked the question: Why is the pay higher for an opthalmologist in Chicago than in Mountain Home? I'd like to know that. I think that we need to level the field. I don't see why we in the rural areas should be penalized because we choose to live in less congested areas.

I'd also like to say that our medical community is rather unique in that we have two hospitals in a town of 15,000, although we serve about a 50,000 population; and my associate and I cover a 12-county area.

I think it's been obvious that the real need today is to stop the differential between rural and urban areas. I believe our supplies cost the same, our malpractice rates are the same, and AP&L charges roughly the same, too.

One of the problems that we face, also, and is probably worse in the smaller areas rather than us, is the slow reimbursement rate on Medicare and the absolute absurdity of Medicaid. Sometimes you can submit a clean claim four times and it never comes through until you finally write and call or such as that.

Last of all, I'd like to point out that I don't think there's a national policy, and probably no one knows the solution for this aging population; but I would like to say, I would like to put in a plug to see some type of committee established and some type of program going on that we do face this issue in the future. I'm getting older and so are you.

Senator PRYOR. You are, not me. [Laughter.] Excuse me.

Dr. MEACHAM. Pardon me, then. It's my mistake.

I've seen it passed around and batted around about sort of a health care IRA. I think it's an idea that needs to be studied greater and probably needs to be applied now for people of my generation.

Thank you, sir. [Applause.]

Senator PRYOR. Doctor, I really thank you for your statement.

Right here, sir.

STATEMENT OF AUBREY C. TRIMBLE

Mr. TRIMBLE. I'm Aubrey Trimble from Wilmar, AR. I'm the State coordinator for the Health Advocacy Services of AARP, and I'm here on behalf of the 300,000 AARP members in the State of Arkansas. And I am really here to learn rather than give advice. However, during the course of the hearing today, I've seen a great deal of evidence placed on the plight of the rural hospitals. I empathize with that because the hospital in Monticello is suffering just the same as the other ones are. But I would also like to point out that there's much more to rural health care than just hospitalization. The home health care and long-term care also need attention as well as the hospitalization part of it. It's total package and needs to be looked at from all angles.

Thank you. [Applause.]

Senator PRYOR. I want to thank you very much. Thank you.

Mr. TRIMBLE. I also think that you and I are on a panel Thursday morning at St. Vincent's Hospital.

Senator PRYOR. Right. This coming Thursday. You're absolutely correct.

Yes, sir.

STATEMENT OF MICHAEL HENZE

Mr. HENZE. Senator, my name is Michael Henze. I'm the administrator of the hospital in Malvern, AR. And I represent a rural facility that is adjacent to an urban area in the State. And I know you've heard a lot today about the urban and rural differential in payment, but I just wanted to add to that and tell you that simply because my facility is some 20 miles down the road from a neighboring city, that our reimbursement is approximately $1,000 per case less for the same treatment of the same Medicare patient. And that means approximately $1.2 million over the last year of patients that we are now currently treating, and we cannot continue to do that and survive under the competitive nature that we have to work in in this area.

Senator PRYOR. Let me ask you a question. Let me tell you what the ultimate dilemma I'm going to have is. I want to see if I can help—it's not fair to ask you to do this. Ultimately, we're going to be asked to make this decision: Do we take the higher reimbursement for the urban area hospitals and do we cut that reimbursement back, or do we just say that the reimbursement will be the same, or do we say that we're going to take the reimbursement of the rural hospitals and make the urban people try to live on that for awhile. So, you can see the dilemma.

Are you saying that your decision would be just to make it equal across the board?

Mr. HENZE. I think there should be much consideration to equalizing the payments for the same type of care provided.

Senator PRYOR. I think that principle is something that I certainly agree with. I think, ultimately—I hope we can do that. Let me just say that's our goal; it's certainly my goal. I really appreciate you coming from Malvern here.

Any more comments that we have? I see a lot of good friends out here in the audience who have been very, very patient all day.

If there are no further comments, I would like to say first how very much we appreciate your attendance today. We've had well over, probably I would say over 300 people in and out of our hearing today. We've had about 20 people who have given some sort of a statement or testimony. All of this is going to be neatly transcribed and typed. It will be placed in the appropriate form and sent to Washington, DC, to the Senate Special Committee on Aging. And we're very grateful for your participation. I don't know of any other Committee on Aging hearings going on this month across the United States, but all I can say is that this has been a good one. We've heard from a good cross section, and before this issue is finally resolved, we may have more such hearings in the State of Arkansas. If so, you will be properly notified, and we express our gratitude at this time.

I'm always afraid of leaving someone out, so rather than calling a lot of names, I will say thank you to all of you, and the meeting is now concluded.

And there being no further statements or questions, the hearing was adjourned and the taking of the official record ended at 4:38 p.m., Tuesday, August 30, 1988.

APPENDIX

MATERIAL RELATED TO HEARING

Item 1

1

Arkansas Federation of Chapters

NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES

WSON BARLOW, President
, Box 40-B
Prescott, AR 71857
Phone 501 887-3524

THOMAS L. BASINGER, Exec. Vice-Pres.
Route 1, Box 185
Huntington, AR 72940
Phone 501-928-5805

MRS. CHLOIS C. NEWMAN, Secretary
745 Rosston Road
Prescott, AR 71857
Phone 501-887-3356

HAROLD A. CATE, Treasurer
721 North Hughes
Little Rock, AR 72205
Phone 501-663-6448

VICE PRESIDENTS

LEROY MIDDLETON, Dist. 1
1104 Madera Street
Jonesboro, AR 72401
Phone 501 972-5473

MRS. GLORIA R. REYNOLDS, Dist.
10500 Arch Street
Little Rock, AR 72206
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WILLIS A. JARVIS, Dist. 3
12 Duvall Lane
Bella Vista, AR 72714
Phone 501 855-1249

JOHN H. DOZIER, Dist. 4
2707 Sherwood Forest Drive
Pine Bluff, AR 71603
Phone 501 535-0896

August 30, 1988

Senator Pryor,

We, in NARFE, feel that the small hospitals in our State serve a very great need for our members. However, we realize that costs are getting out of hand for some of them and that staffing is a continuing problem. The loss of any of them is a blow to some of our members, all of whom are Federal Annuitants or survivors. We hope that some solution can be found to keep a rural health care system in operation.

Following are some ideas that we want to submit to you for consideration as possible solutions to the problem:

a. Working with the Area Agency on Aging to see if staffing of clerical and reception positions can be provided with senior citizens from the affected areas.

b. Contacting the United Ways (or their local equivalents) in the rural areas to see if RSVP (Retired Senior Volunteer Program) people can be used in some way in the hospitals.

c. Within the various affected areas, select a "hub" hospital location, with subsidiary "clinics" in the other areas--simple health problems could be handled in the clinics staffed by nurses/technicians, while more severe medical problems could be sent to (or flown) the "hub" hospital for treatment. Of course, severe problems would be sent/flown to a regional hospital or to Little Rock hospitals.

d. Telephone transmission of patient ailments could be maintained be-tween the local Clinics, c. above, and the Hub and/or Little Rock Hospitals so that expert advice could be given the local Clinic nurse/technician if needed.

The ideas above envision local provision for a "Clinic" similar to a local Doctor's office or emergency room with limited capability, backed up by a "Hub", backed up by a regional hospital or specialized hospital above the regional, if needed. Air transport between all these parts of a system could be provided by helicopter if necessary as decided by the originating clinic, regional or major center hospital. Costs could be borne at all levels of the State, not just the Federal level.

Sincerely yours,

John H. Dozier

John H. Dozier. VP Dist. 4

Item 2

SENATOR DAVID PRYOR

RURAL HEALTH CARE LEGISLATION PENDING
IN THE UNITED STATES SENATE AND
SUPPORTED BY SENATOR PRYOR

Russell Building (202) 224-2353 Washington, D.C., 20510-0402

RURAL HEALTH CARE -- S. 2644
RURAL HEALTH PAYMENT
REFORM ACT OF 1988

The Rural Health Payment Reform Act of 1988, recently introduced in the Senate, proposes changes in health care laws that will strengthen rural health care.

This bill will improve the ability of rural hospitals and health care practitioners to provide high quality health care. This bill addresses the fact that while rural Americans have higher rates of serious chronic illness, accidents, and disability, the uninsured rate in rural communities is 15 percent above the national average and 24 percent above urban levels.

The proposed legislation will make five important changes. First, there will be a guaranteed Medicare prospective payment increase for rural hospitals in FY 1989. This guarantee will allow rural hospitals to make firm management decisions even if the U.S. Department of Health and Human Services changes its variable estimates prior to FY 1989.

Second, changes are proposed in Medicare payments to strengthen financial safeguards for sole community hospitals. These changes will help keep the majority of the sole community hospital payment amount up to date with actual increases in hospital costs. In addition, sole community providers will be exempted from reductions in Medicare payments for capital costs.

Third, the incentive payment amount provided to practitioners in health manpower shortage areas will be increased from 5 percent to 10 percent after October 1, 1989. This provision will be instituted to encourage health care professionals to practice in underserved rural communities.

Fourth, demonstration projects for instructional and consultive services between hospitals and rural physicians will be established. This provision will help rural physicians stay current with new medical practices and developments.

Last, Medicaid demonstration projects will be instituted to improve access to physician services for children and pregnant women. In an effort to curb infant mortality and early childhood morbidity, the U.S. Department of Health and Human Services will be authorized to increase Federal matching funds by not less than 10 percent, not to exceed 90 percent.

RURAL HEALTH CARE -- S. 2597
INTERDISCIPLINARY TRAINING GRANT
PROGRAM FOR RURAL AREAS

The recently introduced Senate rural health care bill entitled Interdisciplinary Training Grant Program for Rural Areas addresses the current shortage of health care professionals in rural America.

The bill authorizes the U.S. Department of Health and Human Services to spend $5 million each year between 1988 and 1991 to provide better incentives for health professionals to practice in rural areas.

The proposed legislation confronts the rural health care shortage in two ways. First, the bill encourages training programs which provide students with health care experience in a rural setting. This provision anticipates that health care workers who practice in rural areas will be satisfied with their work, increasing the number of health care professionals in those areas.

Second, the bill promotes "multidisciplinary training" designed to equip health care professionals to function more effectively in rural health care facilities. This provision recognizes the fact that a health care professional in a rural area may be called on to perform a wider variety of services. If trained in multiple disciplines, health care professionals will be better prepared to for work in a rural setting.

Grants will be available for programs that specialize in preparing health and allied health care personnel for work in rural America.
